

BEHAVIOR MODIFICATION IN REHABILITATION FACILITIES

**AN EDUCATION RESOURCE MANUAL
DEVELOPED FROM
A SEMINAR HELD MARCH 4-6, 1968
IN
HOT SPRINGS, ARKANSAS**

Sponsored by
**Arkansas Rehabilitation Research and Training Center
and
Association of Rehabilitation Centers, Inc.**

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The Seminar, on which this manual is based, was supported in part by VRA Grant RT-13 from the Social and Rehabilitation Service, Department of Health, Education, and Welfare.

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Hot Springs, Arkansas

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Preface

In 1967, at the Annual Workshop of the Association of Rehabilitation Centers, Inc., in New Orleans, a panel presentation on behavior modification in rehabilitation centers was included in the program. The information provided in this panel presentation was so enthusiastically received by the audience that the Education Committee of the Association of Rehabilitation Centers, Inc. decided more information and more effort in this area would be desirable for the membership.

The Education Committee and the Executive Director of the Association of Rehabilitation Centers, Inc., met with representatives of the staff of the Arkansas Rehabilitation Research and Training Center to plan a seminar for rehabilitation center executives and administrators on the efficacy of behavior modification techniques and approaches in rehabilitation center programs. It was also felt that suggestions concerning implementation of such programs would be of help to these participants.

Four recognized leaders in the field of behavior modification research were invited to present theoretical information and research data to the participants of the seminar for their edification and a basis for deliberating on the question of how these techniques and approaches might fit into rehabilitation facility programs. Three of the papers delivered by these four consultants also serve as the base for this education manual. It was the desire of the seminar planners that this manual could be used by rehabilitation center personnel not represented at the seminar.

It was decided by the Planning Committee that only fifty member centers of the Association of Rehabilitation Centers, Inc. would be accepted as participants for this seminar. This was done primarily to insure that the consultants would have ample opportunity for significant spontaneous dialogue with the participants by way of small group discussions.

It should be noted that significant strides have been made through this seminar toward the inclusion of behavior modification techniques and approaches in the armamentarium of rehabilitation facility programs. Further meetings and seminars will undoubtedly be needed for direct implementation of such programs in a wide range of rehabilitation facility services but this has provided an excellent first step for the rehabilitation center field. We wish to express our appreciation, not only to the consultants who did such a magnificent job for the seminar, but also to the participants who listened so attentively during the general sessions

and who worked so hard during the small group sessions to bring to fruition the purpose of this seminar. We hope the reader of this educational manual will at least be stimulated to explore further the potentials of behavior modification programs in rehabilitation facilities and that some will be stimulated to take definite steps toward implementation of these programs into their service activities.

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and Training Center
and
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Association of Rehabilitation
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April, 1968

Introduction

The Rehabilitation Center movement in the United States is experiencing several changes which necessitate our taking a closer look at patterns of rehabilitation services and techniques of providing rehabilitation services to our handicapped citizens. Recent Federal legislation has called for a broadening of services, as well as a broadened scope of clientele for the rehabilitation field. It seems that society is saying to us "rehabilitation of the physically, emotionally, mentally, socio-culturally and educationally disabled individual is not only good from the humanitarian standpoint but also from the economic standpoint".

This mandate for expansion comes at a time when available resources for building more and larger rehabilitation centers are relatively limited. Also, professional staff to man expanded programs or increased numbers of programs are practically nonexistent.

There are several other factors which further complicate this relative lack of facilities and personnel to accomplish the job. One factor which cannot go unnoticed is that the number of our clientele who are experiencing behavior problems or difficulties is constantly increasing. This arises out of the fact that more people are referred to rehabilitation center programs on the basis of behavior problems alone and, as a result, we are looking more closely now at clientele we have served previously in terms of their behavior problems and the similarities which exist between the difficulties of the physically disabled and the behavior problem cases. Not too many years ago very few people bothered to concern themselves with emotional or behavior problems among the physically disabled. Currently many professionals in the field of rehabilitation are more and more concerned with the psycho-social components of disability and are realizing that the purely physical aspects are relatively easy to cope with.

We are becoming increasingly aware also that many of our practices in the past with the physically disabled have, in fact, taught them to be "good patients" instead of becoming good independent members of society.

This is not to imply that we should abandon all of the techniques which have been amassed during rehabilitation's history but that we are in need of a reassessment at this point to determine which of our techniques and programs are actually effective in producing the desired results. We all know of service techniques or approaches which people are continuing to utilize merely because they are habit. We are at a point in time now when society will no longer tolerate this type of approach. We must be able to say to society in general and certainly to our clientele that the services which we offer are provided because of their efficiency in producing the desired results. In other words, we must be able to say that the dollars, whether they come from private or tax funds, are being spent on the most effective techniques available to us at this time. In order that we may be able to do this, we must be innovative and must, above all, utilize our facilities in a research capacity to determine which services are effective. In short, we must be able to predict and control human behavior in the most efficient manner possible to achieve the results society has said it wants from us.

As the four consultants for this seminar indicate in the papers which follow, behavior modification techniques have been utilized with high degrees of success among various groups and populations to achieve the same type of results which we are seeking through the rehabilitation center movement. In those rehabilitation centers where behavior modification approaches are already utilized, very dramatic and encouraging results are found. Therefore, this seems to be one avenue which we can explore more carefully which holds much promise. Each of these papers presents a particular theoretical approach to the business of behavior modification but the one thing which welds them all together into a common purpose is that they are designed to produce the maximum result for the least expenditure of time and energy. Another point which, perhaps, should be more exciting to us in the rehabilitation center movement is that they are imaginative and innovative. While they may not offer us the exact answer we are looking for in every individual center, they do provide a variety of approaches which should allow anyone to begin their planning for a program of behavior modification.

Unless we are able to provide rehabilitation services on a more efficient basis we will not be able to keep up with the increase in referrals which everyone is experiencing at the present time. We must continually look for quicker methods of arriving at the goals of rehabilitation without sacrificing quality of service. If this is done on a rational and realistic basis, the chances of improving the quality of our services is greatly increased.

Behavior Modification for Rehabilitation:

Concepts, Possibilities, and Cautions

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Behavior Modification for Rehabilitation:

Concepts, Possibilities, and Cautions*

The label "behavior modification: or "behavior therapy" has different referents, depending upon whom one is speaking to. The original definition of the term referred to techniques of therapeutic intervention which rested upon what was termed "modern learning theory" (Lazarus, 1958; Eysenck, 1959). This position is most closely associated with the names of H. J. Eysenck and Joseph Wolpe. The early 1960's saw a very rapid renaissance of interest in attempting to apply techniques tied to learning theories to the amelioration of clinically defined abnormal behavior. I use the term "renaissance" quite intentionally because it must be said that this general orientation and, indeed, many of the techniques, were not really entirely new when promulgated by people like Eysenck. For one can look as far back as 1924 to clinical studies by Mary Cover Jones who, as some of you may recall, reduced the unrealistic fear for furry animals in a child by gradually bringing a rabbit close to the child while it was eating. A psychologist by the name of Guthrie also wrote widely about breaking habits, and suggested various procedures and principles which bear some resemblance to what is touted today as new methods in behavioral psychotherapy. One must include also the writings of John Dollard and Neal Miller (Miller and Dollard, 1941; Dollard and Miller, 1950), who suggested that we look at clinical problems in stimulus and response terms; indeed, in 1950 they made an explicit statement to the effect that one might fruitfully conceive of internal processes as responses and obeying, therefore, the same principles as were being established for overt responses. And, of course, the name of B. F. Skinner must surely be mentioned as one of the early proponents of a learning orientation to changing deviant behavior.

*This is a slightly revised text of the speech delivered by the writer at the opening of the Seminar and is intended as an introduction for those relatively unfamiliar with behavior modification.

Some Definitions of Terms

While it probably will be unnecessary to go into great detail about the intricacies of the various learning theories, it may be helpful just to present a few basic concepts that some of you may not be familiar with.

Classical Conditioning. This relates to the work of the Russian physiologist Pavlov, as well as to the work of many contemporary experimental psychologists. The term is used to refer to what happens when one pairs a neutral stimulus (CS), like a tone, with a stimulus (UCS) that elicits a particular response from an animal on an unlearned basis. An example would be placing meat powder, which would be the unconditioned stimulus, on the tongue of a dog and finding that it directly gets the dog to salivate. The salivation would be the unconditioned response. If one then pairs the presentation of the meat powder with the presentation of a neutral stimulus (CS) like a tone, one finds that later on the tone itself will elicit some portion or variation of the unconditioned response, this being called the conditioned response. The dog really doesn't have to do anything to earn a reward, rather it is a function of simply pairing the two stimuli.

Operant Conditioning. This concept, associated with the name of Skinner, refers to the emission of certain behaviors and their differential strengthening or weakening depending upon what consequences they meet with. Perhaps the easiest way to conceive of this is that here the animal or person has to do something in order to earn some "reinforcement" or "reward". The reinforcement itself can take a variety of forms: positive reinforcement refers to a consequence that strengthens the preceding response, the everyday term being "reward"; negative reinforcement, unfortunately, often confused with "punishment", refers to the removal of an unpleasant or negative situation contingent upon the emission of a particular response. An example would be eliminating an unpleasant electric shock from an animal after he has done something you wanted him to do. This will strengthen that particular behavior in the same manner that positive reinforcement will strengthen it. Punishment is the presentation of an unpleasant or aversive stimulus contingent upon the occurrence of a particular response. As you might expect, punishment tends to reduce the probability of a response recurring. A concept common to both classical and operant conditioning

is "extinction" - this refers to what happens to a conditioned response upon cessation of positive or negative reinforcement that has been maintaining it.

As I said, there are all sorts of other niceties and complexities in conditioning, but these terms should be sufficient to help you follow along.

Expansion of the Concept "Behavior Modification"

I have gone into these cursory details merely to give some background to what I believe is an interesting shift in just the past couple of years, and whether one agrees or disagrees with this shift, it is something one ought to be aware of, at least for purposes of discussion at this seminar. What I am referring to is the broadening of the concept "behavior modification" to include ideas, principles, notions, and approaches that go beyond the earlier concern with conditioning alone. Many people, perhaps especially those outside of the early behavior therapy camp, disagreed with the narrow conditioning conception of behavior therapy. It was felt by many clinicians that one could not possibly account for and handle clinical behavior only by paying attention to conditioning principles. Moreover, people came more and more to be dissatisfied with the tendency among most behavior therapists to ignore the internal life of one's patients or clients. Let me try to deal with these two somewhat related issues for the next few minutes.

Internal Events. Let us take, first of all, this question of internal events, for it is really quite central to an understanding of what many behavior therapists are doing. You will recall my mentioning a little while ago that Dollard and Miller suggested we look at internal processes like thinking and feeling in terms of mediating or internal responses. The well-known psychologist from the University of Illinois, O. H. Mowrer, made this suggestion at around the same time in reference to anxiety (Mowrer, 1939). I think it is fair to say that this position is not a terribly popular one these days amongst behavior therapists, most of whom construe the word "behavior" as referring solely to directly observable overt acts (cf. Ullmann and Krasner, 1965). Be that as it may (for my assessment of the scene may be inaccurate), there is a difference of opinion between those who go to the more overt behavior side, especially the Skinnerians, as compared to those who are willing to make inferences about internal events (e.g., Davison, in press; Staats and Staats, 1963; Bandura, in press). So, this first change in behavior therapy can be seen as one

which represents an increased concern with what are usually considered to be internal or mediating processes in a human organism, and it seems to me that this is a necessary, fruitful and readily justifiable approach.

Beyond Conditioning. A related shift in the field is, I believe, well represented by one of my fellow panelists, Dr. Arnold Goldstein. With his colleagues Kenneth Heller and Lee Sechrest (Goldstein, Heller and Sechrest, 1966), Dr. Goldstein has suggested that behavior modifiers be concerned not only with principles of conditioning, but with the field of general experimental psychology as a whole. This suggestion has been made independently by others as well (e.g., Davison, 1966) but not quite so compellingly and with as much corroborating data as in their recent book. This is not a trivial shift in direction for Goldstein, Heller and Sechrest devote considerable space to a review of studies in social psychology for their possible bearing upon clinical problems. Dr. Goldstein, I am sure, will outline some of this research himself.

I have tried so far to point out some complexities on the contemporary scene which are useful to keep in mind when evaluating the remarks of various behavior therapists. Such essentially philosophical positions need not be agreed with, but they ought, at least, to be understood.

To sum up these introductory remarks, then, I would like to suggest that we regard behavior modification as both an approach and as a set of techniques. As an approach, I believe it is fruitful to regard behavior modification as an orientation to clinical problems consistent with that of experimental psychology as a whole, and not to limit it to studies in classical and operant conditioning. The behavior modifier, then, has a strong identification as an experimentally-minded psychologist, with the usual concern for careful observation, experimentation, and operational definitions of terms. The behavior modifier, as it were, does not forget his training as a psychologist when he enters the clinical situation; I'd argue that in many clinical programs and clinical training facilities, the relevance of one's earlier training in psychology is not always clear when he is confronted with the exigencies of clinical problems. As a body of techniques, furthermore, behavior modification can be seen as a set of procedures which, at least for the present, seem to make sense in terms of experimental psychology, and seem indeed to be tied to various principles arising from experimental psychological research.

I would like at this point to mention several areas of clinical research which I believe are relevant for the various rehabilitation facilities represented at this seminar. I will also suggest some problems and cautions which I believe are appropriate to keep in mind when considering the adoption of any of the programs which will be described now.

Operant Conditioning

Nonverbal Behavior. Perhaps the best known work with patients in institutional settings is that of Teodoro Ayllon and his associates (Azrin, Michael, Haughton). Ayllon's work grew out of the original work of B. F. Skinner and Ogden Lindsley (Lindsley and Skinner, 1954). The basic assumption made by Ayllon, who can be characterized as a Skinnerian interested in clinical problems of psychotic patients, is that the psychologist's primary concern should be with the overt behavior of the individual and not with any **presumed** underlying internal conflicts or mechanisms. Over the past several years, Ayllon has initiated several interesting programs in a couple of state hospitals in Canada and in this country. Perhaps some of you have already heard of the following demonstration. Patients who were designated as "problem-eaters" were put on a regime in their wards such that their reluctance to eat properly was no longer followed by cajoling and coaxing and, in short, increased attention from the nursing staff, who had been trying to get the people to eat. Rather, it was reasoned that such well-meant attention was reinforcing to these people for not eating. And so, something like the following was done; patients were allowed into the dining room only during specified hours, and if they did not arrive within a certain amount of time they missed the meal. As they began to shape up, the period of time during which they would be allowed into the dining room was continually shortened, until most patients were arriving right on time. An extension of this study was to make patients do certain things in order to get into the dining room, like dropping tokens into slots. While these achievements may seem somewhat trivial, it should be kept in mind that this change in procedure effected certain desirable changes which had not been achieved by the staff for many years previously.

Just to mention another example, there was a case of a female schizophrenic patient who had been making quite a nuisance of herself by collecting towels. Ayllon (1963) arranged for towels to be delivered to her room in great

quantities, reaching the point where the woman apparently became quite fed up with the towels and insisted that they be taken away.

Perhaps the most ambitious operant conditioning program is that reported by Ayllon and Azrin (1965). An extensive series of studies conducted at Anna State Hospital in Illinois heralded the onset of the so-called "token economy", of which there are many now springing up in mental institutions across the country. The core of such programs is that patients are required to earn their right to engage in such behavior as sitting in comfortable chairs, sleeping in comfortable beds and, in short, obtaining those aspects of hospital life which hitherto have been seen as the undeniable right of patients in various hospitals. Overlooking, for the time being, the moral and legal implications of such procedures, it can be said that very marked beneficial changes have been effected by such procedures. Patients have been encouraged to attend their off-the-ward assignments and have been, in short, taught to behave in a far more appropriate fashion than had been possible with earlier therapeutic procedures.

An important feature of all of Ayllon's work is the use to which he puts nonprofessional personnel. In each instance it is possible to specify procedures in enough detail such that they can be implemented by hospital personnel like nurses and aides. Once the assumption is made that meaningful therapy can be conducted outside the holy confines of the psychotherapist's consulting room, possibilities arise for taking quite seriously what the patient does during the many hours when he is interacting with aides, nurses and other patients. Although people like Ayllon are yet to demonstrate the kinds of changes that lead to release and truly fruitful extra-hospital living, these investigators have shown convincingly that many nontrivial changes can be effected within the model of the psychologist supervising the implementation of various operant programs that are actually carried out by nonprofessionals. I am sure Dr. Lindsley will have more to say about this in his own presentation.

Verbal Behavior. Another related area of research, likewise, characterized as operant conditioning, is the so-called verbal conditioning work. This kind of research has been going on with psychotic patients since around 1958, when Krasner (1958) and Salzinger and Pisoni (1958) independently illustrated the efficacy of these procedures with

hospitalized patients, extending the original work of Greenspoon (1951). The procedure entails selectively reinforcing people, as they talk, for certain classes of verbal behaviors, the usual result being that one can get a person to emit certain kinds of verbal responses that he has not been emitting hitherto. There have been many studies in this tradition, but to my mind the most impressive are those of Meichenbaum. Meichenbaum found that he could reduce the frequency of what he called "sick talk" in several psychotic patients by reinforcing them for "healthy talk". A most significant aspect of his work is the demonstration that such verbal conditioning of healthy talk can generalize to other situations in a most powerful fashion. Indeed, he found that after he conditioned healthy talk in schizophrenics, their performance on a different task - interpretation of proverbs - was found not to differ significantly from that of a matched control group of medical patients with no psychiatric history or central nervous system pathology, indicating that his verbal conditioning procedures improved the performance or thinking of these schizophrenics on a very central dimension of abstract thinking to a degree indistinguishable from people designated as normals (Meichenbaum, 1966). Meichenbaum is engaged in further work of this kind at the University of Waterloo in Canada.

Physical Problems: Moving over to physical problems in rehabilitation, let me allude to the work of Meyerson and Michael (Meyerson, Kerr and Michael, 1967). Again, following a Skinnerian model, these men have succeeded in teaching physically handicapped people to engage in very complex and beneficial behavior. In several articles, they have very compellingly shown the futility of giving up on patients with the excuse that they are "poorly motivated". They point out that "motivation" should more fruitfully be seen as the lack of success on the part of the therapist in finding appropriate incentive and reinforcement, as well as in not formulating a treatment program that is broken down into a series of small enough and manageable steps. One of the many cases they describe in a recent article is that of a 16-year-old quadriplegic who was unable to walk, had tremors in his upper extremities and had, in short, extremely poor muscular coordination in addition to problems in memory and speech. The occupational therapist had selected as a worthwhile task the boy's learning to type by hunt-and-peck but, over several months, she had not succeeded in getting the boy to concentrate for more than five or seven minutes at a time, after which the patient would stop and call for

the therapist's attention. Meyerson and Michael analyzed the problem in terms of the occupational therapist unwittingly reinforcing nontyping behavior. Inasmuch as it seemed quite clear that the patient liked to have the therapist around, Meyerson and Michael explained to the therapist that she must make her attention and presence contingent upon certain typing behaviors on the part of the patient and not contingent upon his stopping to type, and calling for assistance. The patient seemed to realize rather quickly that he could engage in even more social interaction and, indeed, more interesting interaction if he typed more and more. In a relatively short time the patient was typing for 30 minutes at a stretch, with increasingly better accuracy. He was also clearly enjoying his achievements very much and, as mentioned before, was not being at all deprived of the attention which he did, indeed, like to receive. A sort of bonus is that he began to be treated more as an adult than as a helpless child, which he had indeed appeared to be prior to this contingency planning. Other cases are reported as well, but perhaps it would be best to wait for our small group discussions for further description and argument.

Control of Emotional Reactions

Let us stay within the general area of what might be seen as physical or at least psychosomatic problems, albeit conceptualized in a nonoperant fashion. I would like to allude at this point to the implications of some recent research for application in institutional and rehabilitation settings. I would like to stress that these remarks now refer to possible applications of research; I will be dealing with things which I believe might be applied in ways I do not believe they have as yet been applied. Peter Lang at the University of Wisconsin has, with several of his students for the past few years, been showing that it is possible to train normal human subjects to control their heart rate (e.g., Hnatiow and Lang, 1965; Lang, Sroufe and Hastings, 1967). While this may not seem terribly surprising to those familiar with Eastern practices, nonetheless to the Western eye it seems quite striking that, in a relatively short time, they are able to train human subjects to bring their heart rates within certain specified limits, like between 68 and 75 beats per minute. Their procedure entails recording the heart rate and simultaneously showing it visually to the subject, demarcating the region within which the subject is supposed to keep his heart rate. Thus, for example, the person may see his heart rate to be to the right of a particular area on a meter, the instruction being to bring the heart rate over to the left.

It has been shown repeatedly that subjects can indeed perform this feat. It is interesting to note that research so far has failed to discover how people, in fact, do this. One can speculate as to changes in body position, respiratory rate, and thinking certain thoughts that are exciting or depressing, but much research remains to be done to decide what in fact is going on. That is perhaps more the concern of the experimental psychologist, but for the applied psychologist, some thought might be given to the use of such a procedure. For example, patients for whom control of heart rate is desirable might be wired up to such an apparatus to see if they can bring their own heart rates down to a level designated by the attending physician as preferable.

A related area of endeavor is some work that I myself have been engaged in over the past few years. This has to do with training in muscular relaxation, taken primarily from the work of Edmund Jacobson (1938). While people are trained in muscle relaxation primarily for purposes of desensitization, as will be described shortly, it seems to me that such training, in and of itself, can be valuable for patients who have trouble controlling their emotional reactions and perhaps, thereby, endangering their own physical health. This procedure, which more recently I have been doing by means of tape recordings, entails teaching the patient where he is tense muscularly and then how he can release that tension and achieve a state of muscular relaxation and psychological calm. In some respects the training does resemble hypnosis, but there are problems with that concept which lead me to concentrate instead on the relaxation and not on any trance state that is sometimes apparently induced. The main thing is that it is usually possible within half a dozen to a dozen sessions to train even highly anxious people to control their emotional reactions. This would seem not only of benefit in a strictly physical sense, but also would seem to contribute to a highly desirable sense of competence and self-control, which would certainly seem valuable for people with both physical and mental problems.

Reduction of Unrealistic Fears

In connection with muscle relaxation, I have likewise been engaged for some time in reducing neurotic or inappropriate fears in human beings by means of a procedure devised by Joseph Wolpe (1958). Some of you may have heard of this technique of "systematic desensitization". The procedure entails determining for a patient or client what it is he is afraid of, and then concretizing this fear in terms of hierarchy of specific situations of increasing difficulty. For example, someone afraid

of authority-figures would have a hierarchy drawn up for him that could sample situations along this dimension. One begins with easy situations, like speaking to people who pose few problems, and goes gradually all the way up to, say, asking the boss for a raise. Once this hierarchy is drawn up, the person, who has concurrently been trained in deep muscle relaxation, has these scenes presented to him in his imagination, with certain specific rules as to how long a scene is presented and what happens if the scene is disrupting to the person's relaxed state. This procedure might be appropriate to go into in more detail in the small group discussions, but I did want to allude to it in this initial presentation. Obviously, such a procedure would have application for many of you with certain of the patients you are responsible for treating, for there is ample research demonstrating its effectiveness in markedly reducing fears (e.g., Lang and Lazovik, 1963; Paul, 1966; Davison, 1968).

Conclusion

In this brief time I have attempted to provide what I consider to be a sampling of behavior modification as it may be of special interest to you as people involved in rehabilitation facilities. It has been solely for ease of exposition that the examples I have cited have been single problem cases. Of course, the situation is usually otherwise. Patients come with multiple problems, and usually one mounts a multifaceted attack, perhaps desensitizing fear of authority-figures, training in assertive behavior, teaching to relax in the life-situation, and so forth. Indeed, the most difficult work is usually in deciding what to treat and in what order. For example, considerable clinical ingenuity and experience are necessary to draw up an anxiety-hierarchy which samples adequately from a dimension that is relevant to desensitize a person to. The clinical behavior therapist must bring to bear the kinds of interpersonal skills which seem to characterize also the activity of those who do not identify themselves as behavior modifiers. I can state, in my own case, that much of the time my therapeutic behavior is indistinguishable from that of a Rogerian. What does seem to define the behavior therapist is his systematic, deliberate attempts to utilize specific behavioral techniques within an ongoing clinical relationship characterized by respect, warmth, and trust. This is, of course, no easy job and is, above all, not a superficial endeavor, as is sometimes mistakenly assumed by those unfamiliar with the field.

While I do not feel it is appropriate in this speech to get into hairy theoretical-research issues, it ought at least to be made

clear that behavior therapists are keenly aware of the need to demonstrate that their beneficial results are due to the psychological processes that are asserted to be operating in the various procedures. To take systematic desensitization as an example again, it is clear in looking at the procedure that we have a therapist who plays close attention to the client's problems, performs unusual operations such as training in deep muscle relaxation and/or hypnosis, conveys a desire to help and perhaps also a feeling he can do so and, in short, does many things beyond presenting to the imagination of a deeply relaxed person a series of anxiety-provoking situations. The prevailing view is that the efficacy of the procedure derives from a counter-conditioning process, but this is not demonstrable merely by fiat or by pointing to the many stunning clinical successes. Rather, one must carefully design experiments which systematically vary conditions in such a way as to rule out such factors as "attention", "placebo", and "therapist-enthusiasm". A recent study of my own (Davison, 1968) may be of interest to some of you as an example of the kind of research which many of us are engaged in to find out whether our procedures are working for the reasons we like to think.

Let me now sound a few notes of caution in considering the implementation of any of the suggestions made by me or by any of the following speakers. As with any new endeavor, one should try very hard to provide for adequate and reasonable evaluation. As has been documented in many psychological experiments, beneficial changes frequently occur following the introduction of new procedures per se. It is natural for investigators to convey their enthusiasm, and the patients involved do note that something new and different is being done to them. While the gains which may follow are not necessarily illusory or even short-lived, it is nonetheless important to distinguish improvements due to suggestion or placebo of the so-called "Hawthorne effect" from those due to the actual operation of the various procedures. In essence, what I am suggesting is that research evaluation programs be implemented along with the introduction of any specific techniques. Not only will this rebound to the advantage of the particular installation, but it will also clearly contribute to the extension of knowledge in general. Certainly no one can, at this stage of the game, be smug about even sometimes impressive results, and one should always maintain a self-critical attitude and sometimes even a sense of humor about what he is doing.

It need hardly be emphasized how important it is for new techniques to be applied correctly. If one were, for example, investigating

the effects of a particular surgical procedure, it would require initially that the operation be done properly. The procedures I have outlined, and many more which you may come upon in your own reading, appear deceptively simple. They are not. It requires careful planning and training to create even the possibility of effective new programs. I wish to make this caveat very explicit because I have many times been appalled by well-meant but inept application of some behavior modification techniques.

A central characteristic of these procedures is, as is probably already clear to you, its openly manipulative nature. I think it can be demonstrated or, at least, reasonably asserted, that all therapies are manipulative in nature (Truax, 1966, has shown this even for Carl Rogers' "nondirective therapy"), and perhaps a defining characteristic of behavior therapy is that this characteristic of manipulation is publicly admitted and dealt with. As Perry London (1964) of the University of Southern California has stated, either we can manipulate or we cannot, and if we cannot, perhaps we have no justification for being in business. This feature of manipulation obviously raises ethical questions which are especially acute when patients have little choice, or little understanding of the things being done to them. One need not raise the specter of the mad scientist to justify concern: we can impute good motives to all behavior modifiers and still be concerned with the ethical and even legal problems involved in the application of specific techniques. I have already alluded to possible legal problems that may be involved in denying mental patients things like food and such other niceties. My colleague, James Geer, at Stony Brook, is currently writing an article for a law journal with a lawyer colleague of his, exploring the legal implications of some of these behavior therapy procedures. While I do not think that these problems need deter us from seriously considering these techniques and the general approach, they are nonetheless real issues and should be dealt with openly. Of course, one should always keep in mind the alternatives that are available. This very conference attests to the realization that the kinds of things being done now are not getting the job done, are not satisfying to those most directly responsible for effective programs. Indeed, more radical things have been done to institutionalized patients than denying them access to a dining hall if they do not have a token in hand; easy examples of this are electric shock therapy and lobotomy.

References

- Ayllon, T. Intensive treatment of psychotic behavior by stimulus satiation and food reinforcement. Behaviour Research and Therapy, 1963, 1, 53-62.
- Ayllon, T. and Azrin, H. H. The measurement and reinforcement of behavior of psychotics. Journal of the Experimental Analysis of Behavior, 1965, 8, 357-383.
- Bandura, A. Principles of behavior modification, New York: Holt, in press.
- Davison, G. C. Appraisal of behavior modification techniques with adults in institutional settings. In C. M. Franks (Ed.) Assessment and status of the behavioral therapies and associated developments. New York: McGraw-Hill, in press.
- Davison, G. C. Differential relaxation and cognitive restructuring in therapy with a "paranoid schizophrenic" or "paranoid state". Proceedings of the 74th Annual Convention of the American Psychological Association, Washington, D. C.: APA, 1966.
- Davison, G. C. Systematic desensitization as a counterconditioning process. Journal of Abnormal Psychology, 1968 (in press).
- Dollard, J. and Miller, N. E. Personality and Psychotherapy. New York: McGraw-Hill, 1950.
- Eysenck, H. J. Learning theory and behavior therapy. Journal of Mental Science, 1959, 105, 61-75.
- Goldstein, A. P., Heller, K., and Sechrest, L. B. Psychotherapy and the Psychology of Behavior Change. New York: Wiley, 1966.
- Greenspoon, J. The effect of verbal and nonverbal stimuli on the frequency of members of two verbal response classes. Unpublished doctoral dissertation, Indiana University, 1951.
- Hnatiow, M. and Lang, P. J. Learned stabilization of cardiac rate. Psychophysiology, 1965, 1, 330-336.
- Jacobson, E. Progressive relaxation. Chicago: University of Chicago Press, 1938.

- Krasner, L. A technique for investigating the relationship between the behavior cues of the examiner and the verbal behavior of the patient. Journal of Consulting Psychology, 1958, 22, 364-366.
- Lang, P. J. and Lazovik, A. D. Experimental desensitization of a phobia. Journal of Abnormal and Social Psychology, 1963, 66, 519-525.
- Lang, P. J., Sroufe, L. A., and Hastings, J. E. Effects of feedback and instructional set on the control of cardiac rate variability. Unpublished paper, University of Wisconsin, 1967.
- Lazarus, A. A. New Methods in psychotherapy: a case study. South African Medical Journal, 1958, 33, 660-663.
- Lindsley, O. R. and Skinner, B. F. A method for the experimental analysis of the behavior of psychotic patients. American Psychologist, 1954, 9, 419-420.
- London, P. The Modes and Morals of Psychotherapy. New York: Holt, Rinehart and Winston, 1964.
- Meichenbaum, D. H. The effects of instructions and reinforcement on thinking and language behaviors of schizophrenics. Unpublished doctoral dissertation, University of Illinois, 1966.
- Meyerson, L., Kerr, Nancy, and Michael, J. L. Behavior modification in rehabilitation. In S. W. Bijou and D. M. Baer (Ed.) Child development: readings in experimental analysis. New York: Appleton, 1967, 214-239.
- Miller, N. E. and Dollard, J. Social learning and imitation. New Haven: Yale University Press, 1941.
- Mowrer, O.H. A stimulus-response analysis of anxiety and its role as a reinforcing agent. Psychological Review, 1939, 46, 553-565.
- Paul, G. L. Insight vs. Desensitization in Psychotherapy: An Experiment in Anxiety Reduction. Stanford: Stanford University Press, 1966.
- Salzinger, K. and Pisoni, Stephanie. Reinforcement of affect responses of schizophrenics during the clinical interview. Journal of Abnormal and Social Psychology, 1958, 57, 84-90.

- Staats, A. W. and Staats, C. K. Complex Human Behavior: A Systematic Extension of Learning Principles. New York: Holt, Rinehart, and Winston, 1963.
- Truax, C. B. Some implications of behavior therapy for psychotherapy. Journal of Counseling Psychology, 1966, 13, 160-170.
- Ullmann, L. P. and Krasner, L. (Eds.) Case Studies in Behavior Modification. New York: Holt, 1965.
- Wolpe, J. Psychotherapy by Reciprocal Inhibition. Stanford: Stanford University Press, 1958.

Relationship - Enhancement in Counseling and Psychotherapy

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The historical development of individual psychotherapy, when viewed from a broad perspective, may be accurately characterized in terms of the marked diversity of theoretical viewpoints put forth, the varied nature of specific techniques recommended and, in general, the numerous different paths this development has followed. As examples of such psychotherapeutic diversity, one may point to the wide variety of basic concepts utilized to explain patient behavior, the time period of the patient's life focused upon, the nature of the therapist's interventions, the overt and implicit characteristics of the tasks required of the patient, and the very language of the therapeutic give and take. Agreement on basic aspects of the therapeutic transaction by proponents of different approaches is far less common. On one point, however, the degree of both theoretical and operational convergence is very marked, namely the centrality accorded the interpersonal relationship between therapist and patient. The long standing psychoanalytic emphasis upon transference and, more recently, countertransference effects; the relationship focus in Snyder's (1961) more eclectic approach to psychotherapy; the major interpersonal components in Grinker's (1961) transactional model of therapy, Jackson's (1961) interactional approach and Wolberg's (1954) directive form of treatment; and Rogerian (1961) concern with unconditional positive regard are but examples of the pervading therapeutic importance which has been accorded the patient-therapist relationship. It may also be noted in this context that interpersonal determinants of the therapeutic outcome have yet to be shown to be any less central to the success of the behavior therapies. Perhaps it will suffice here to place ourselves in agreement with Bordin (1959) who has commented:

The key to the influence of psychotherapy on the patient is in his relationship with the therapist. Wherever psychotherapy is accepted as a significant enterprise, this statement is so widely subscribed to as to become trite. Virtually all efforts to theorize about psychotherapy are intended to describe and explain what attributes of the interactions between the therapist and the patient will account for whatever behavior change results. (p. 235)

¹This paper has been prepared in conjunction with research supported in part by MH-1072, from the National Institute of Mental Health, U. S. Public Health Service.

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It is clear then that the vast majority of theoretical approaches to psychotherapy, despite their divergence on other grounds, come together in their common emphasis on interpersonal constructs mediating between patient and therapist. However, the specific nature of these constructs remains unclear, and hence their more effective use is retarded. Transference, countertransference, interaction, transaction, relationship - these are the terms of primary concern here. Not only does their meaning differ in ways which remain to be clarified, but different writers use the same term to include differing ranges of phenomena.

A directly analogous picture emerges when one leaves the domain of theoretical statements about the therapy relationship to examine research dealing with its impact upon the therapeutic outcome. In a manner strikingly parallel to the theoretical status of "relationship", outcome studies conducted by Bown (1954), Hunt, et al. (1959), Parloff (1961), Holt and Luborsky (1952), Sapolsky (1965), Truax (1961), Van der Veen (1965) and others combine to present an unequivocal demonstration of a major, positive influence of the therapy relationship upon treatment outcome. Equally apparent, however, is the scant degree of overlap in these studies in their operational definitions of "relationship". Q-Sorts, Personal Reaction Questionnaires, therapist ratings, Client and Therapist Affect Scales, the Picture Impressions Test, and need scales are among the several such research definitions which have been used.

Of what consequence, one may ask, is the diversity and frequent ambiguity of these various research and theoretical definitions of relationship? Since research and clinical experience combine to unequivocally demonstrate its therapeutic centrality, why need one be concerned about a lack of precision and agreement in "its" definition? Our personal view of contemporary psychotherapy is of a set of precesses which are grossly inefficient in several major respects. For example, the excessive length of treatment, the grossly inadequate number of patients seen when compared with the numbers for whom psychological intervention is needed, the several classes of persons excluded from treatment altogether solely on the basis of clinical lore, and the unreasoned yielding to traditionalism by most therapeutic variables can be achieved, treatment can be shortened, more patients can participate, a broader range of persons can be viewed as acceptable in terms of their potential for change and, of greatest consequence, the development of completely new approaches to altering patient behavior can be encouraged. It is with these aims as our motivation that this paper will offer a start at reconceptualizing the meaning and therapeutic uses of the psychotherapeutic relationship.

At the heart of this reconceptualization lies the social-psychological construct, interpersonal attraction. We choose here to focus

almost exclusively upon interpersonal attraction as the most meaningful way of viewing the therapist-patient relationship not because of any greater parsimony implied by the construct but because, as we shall attempt to demonstrate, viewing the psychotherapeutic relationship in this manner enables us to bring to bear upon relationship a wide variety of social-psychological findings relevant to antecedents and consequents of interpersonal attraction. If research should demonstrate the appropriateness of extrapolating these parameters of interpersonal attraction from the social-psychological laboratory to the psychotherapeutic setting, then we have greatly increased our ability to understand and manipulate the therapist-patient relationship toward psychotherapeutic ends. The investigations discussed below are all concrete expressions of this extrapolatory research philosophy.

Interpersonal Attraction and Interpersonal Influence

Perhaps one of the most frequently replicated social psychological findings is the manner in which interpersonal attraction increases receptivity of interpersonal influence. The more "A" likes "B", the more "A" is willing to be influenced by "B". It is of more than passing interest to note that this predicted effect of interpersonal attraction on interpersonal influence is a significant point of convergence among the cognitive balance theories which have been developed in recent years by Festinger (1957), Heider (1958), Newcomb (1956), and Osgood and Tannenbaum (1955). One of the early experimental tests of this predicted effect was conducted by Back (1951). His subjects were constituted into randomly assigned pairs and, prior to their meeting, were structured by Back for either high or low within pair attraction. This structuring, which subsequent sociometric measurement indicated was successful, was oriented in terms of either personal liking for the future partner, task outcome or group prestige. Prior to meeting with his partner, each subject was given a set of three pictures about which he was to write a story. Although each subject was led to believe that he and his partner had responded to the same set of pictures, there were, in fact, slight differences between the sets. After completion of their initial story writing, members of each pair were brought together for a discussion which was structured as an opportunity to improve their own stories. Following this discussion, and again working apart, each subject rewrote his stories as he wished. The criterion, interpersonal influence, was reliably measured in terms of changes from the preliminary to the final stories which were in the direction of the subject's partner's stories. Results demonstrated significantly more influence attempts and successful influence in the high attraction condition. Burdick and Burnes (1958), Gerard (1954), Gordon (1952), Rasmussen and Zander (1954), Sapolsky (1960), Seashore (1954), and others have all independently reported concurring results. Thus,

we may conclude that in the social-psychological laboratory, interpersonal attraction has a direct and robust maximizing effect upon openness to interpersonal influence. As such, it made uncommonly good sense to us to begin our extrapolatory research efforts by examining this finding in a clinical treatment setting. Our major hypothesis predicted that patients led to hold high attraction toward their psychotherapist would be more receptive to the latter's influence attempts than would patients in whom low attraction to the therapist was induced. Thus, not only did we seek here to examine in a psychotherapeutic context a basic and often replicated social-psychological experimental procedures involved. Our subjects were 82 university students seen for psychotherapy at our Psychological Center. Five experimental conditions were constituted. As in Back's (1951 original laboratory study, these were high and low induced attraction based on the degree to which the patient would like the therapist as a person, high and low induced attraction based on the degree to which the patient would like the therapist as a person, high and low induced attraction based on the probable success of the therapy, and a control condition. All patients participated in an intake interview and a pretherapy testing session - the last test of which provided the fulcrum for our structuring of attraction. For example, in our first condition (high attraction based upon liking the therapist) the last test given was called the Patient-Therapist Matching Scale, a scale consisting of items describing ways in which a therapist might behave during a therapy interview. Scale instructions were such that the respondent was requested to rate each statement in terms of how strongly he wished his as-yet-unmet therapist to behave in the manner described. In short, the scale permitted the patient to indicate the kind of therapist with whom he'd like to work. Following a fictitious scoring procedure, the intaker then delivered the high attraction structuring to the patient:

We have carefully examined the tests you took in order to assign you to a therapist with whom you would like to work most. We usually can't match a patient and therapist the way they want most, but for you we have almost exactly the kind of therapist you described. (Intaker then shows the patient how well his Matching Scale matches on purportedly representing a composite of the judgments of many patients already seen by the therapist to whom he is to be assigned). As a matter of fact, the matching of the kind of person you wanted to work with and the kind of person your therapist is, is so close that it hardly ever happens. What's even more, he has often described the kind of patient he likes to work with most as someone just like you in many respects. You two should get along extremely well.

Our patients assigned to the low attraction (based on liking the therapist) condition were treated identically, save for the structuring tag line which was: "Frankly, we don't have anyone on our staff who fits your description closely, but Mr. _____ is like your description in some ways. You and he will probably get along all right." Whereas, the basis for manipulating attraction in the condition just described was the degree to which the patient would like his therapist, the remaining experimental conditions revolved around the supposed likelihood that a given therapist would (high attraction) or would not (low attraction) be especially able to help resolve the patient's specific presenting problems.

It should be noted that patient assignment to both experimental condition and therapist were randomly conducted. The patient, following attraction structuring, then met with his therapist for the initial therapy interview. Each interview tape was then subjected to content and timing analyses according to procedures developed by Ashby, et al. (1957) and by Mahl (1956). These analyses provided our several dependent variable measures of patient openness to therapist influence.

Our measures of interpersonal attraction in this investigation, as well as in those to be discussed below, included (but were not limited to) the Picture Impressions Test (Libo, 1956) which is a projective technique consisting of four plates depicting therapy-like situations to which the patient is requested to respond in a manner analogous to TAT administration; the Client's Personal Reaction Questionnaire, a scale developed by Ashby, et al. (1957) as a measure of the client's evaluation of the therapy relationship; and the Therapist's Personal Reaction Questionnaire, an analogous relationship evaluation completed by the psychotherapist.

Our results were as follows. A series of analyses demonstrated that as a group our attraction inductions were unsuccessful. More specifically, while our patients processed through either type of high attraction structuring did indeed increase in attraction toward their therapist, patients structured for what we viewed as "low" attraction did not respond accordingly. Their view of their therapist, while not as favorable as was true for patients structured for high attraction, nevertheless proved more favorable than was the case for our nonstructured controls. When one considers our exact attraction-induction instructions, as they compare with those typically used in the social-psychological laboratory, a plausible basis for our failure here emerges. Our structuring of high attraction paralleled directly those found in the laboratory setting, and our results came very close to doing so also. Our low attraction structuring, in contrast, had

to materially depart from that typically provided in the laboratory context. There, subjects are characteristically told that they "will not like their partners", "will have trouble getting along with them", and so forth. We felt bound, by ethical considerations, to modify and moderate such low attraction structuring as it was to be delivered by us, not to laboratory subjects, but instead to psychotherapy patients. Thus, we have tentatively inferred that our moderating of low attraction structuring seriously truncated the potential spread in attraction between our high and low conditions and, accordingly, prevented us from examining in the manner we had planned the effects of interpersonal attraction upon interpersonal influence.

To this point our focus has been upon "induced" attraction, that is, the level of attraction a patient may hold toward his therapist as a result of our experimental structuring. A second type of attraction is relevant, however. We speak here of what might be termed "resultant" attraction, that is the attraction with which a patient views his therapist as a result of their initial therapeutic session. The next set of questions we addressed to our data made use of our information on patient resultant attraction and sought in correlational terms to examine the attraction-influence relationship more naturalistically. Our results indicated that when patient attraction to the therapist is high, the patient (1) is less covertly resistive, (2) talks more, (3) is self-descriptively sicker, and (4) has more favorable prognostic expectancies for himself. Correspondingly, the more attracted the therapist is to the patient, the more the patient (1) talks, (2) is open in the content of his communications, and (3) the less covertly and overtly resistive the patient is. We have here, therefore, correlational support for the association of interpersonal attraction and interpersonal influence.

This study's second hypothesis, also extrapolatory in nature, grew from Jones and Thibaut's (1958) classification of two-person interactions and, in particular, their discussion of reciprocally contingent relationships. In such relationships both participants function as variable responders, each alert to the incoming cues from the other and each in turn acting as a partial cause of the other's behavior. In psychotherapy, this model may be expressed in part by the position that the therapist's behavior, rather than being largely standardized across a series of patients, is in large measure a function of specific patient characteristics - such as their attraction to the therapist. Thus, we hypothesized, and found support for, the prediction that patients highly attracted to their therapists would be rated as more attractive by their therapists than would patients holding low attraction to their therapist. We may note in passing that this finding is consistent

with the psychoanalytic law of talion, in which transference and countertransference are held to covary.

In general terms, therefore, we view the tests of our two hypotheses as providing tentative evidence to underscore the degree to which attraction remains a potentially valuable means of both defining and examining the psychotherapeutic relationship. If this be the case, and since our attempt to induce attraction by the use of single-trial, verbal structuring procedures failed, one is immediately led to search for alternate means of inducing patient attraction. We are, thus, led to the second study in this series, an investigation in which Jay Land of our research group was principal investigator.

The Overheard Message

Again basing both our hypotheses and experimental procedures on social-psychological findings, we drew on the attitude change studies reported by Walster & Festinger (1962) and Brock & Becker (1965). In each of these investigations a comparison was made of two methods of presenting the study's persuasive message to subjects. In both condition "E" delivered the message verbally to an accomplice with the audio arrangement such that Ss, who were behind a one-way mirror, could also hear it. In the Regular Hearing condition, all Ss were told that the discussants knew that they (the Ss) were listening. In the Overhearing condition, Ss were led to believe that "E" and his listener did not know the Ss were listening in. In both studies Ss who overheard the message changed on the relevant attitude significantly more than did Ss in the regular hearing conditions.

The relevant attitude dimension in Land's study, as in all our other investigations, was patient attraction to the therapist. His subjects were 48 VA psychiatric patients who were assigned to four experimental conditions. At the start of the experiment each patient was told:

Like most VA hospitals, we do a lot of research trying to find better ways to help patients. Right now, on the 7th floor, a group of doctors from the VA Central Office are doing some research on interviewing. They are trying to find out something about the effectiveness of having two doctors at the same time talk with one patient. Now, many people have pointed out that sometimes patients seem to understand other patients better than doctors do and we'd like to find out how that works. So, for this study, we're asking 8th floor patients to listen in on one of the experimental interviews going on on 7 and then to check off their opinions on a check list.

Regular hearing condition patients and patients in the corresponding control group were then told: "Of course, both the interviewers and the patient know you'll be listening in." Patients in the Overhearing experimental and control groups were told: "Of course, the interviewers and the patient don't know you're listening in today." The patients then put on earphones which purportedly were connected to the 7th floor interview room but which, in actuality, were connected to a tape recorder. The tape thus played to the two control groups (regular and overhearing) consisted of two psychiatrists interviewing a patient. All three taped voices were in actuality actors. The task requested of all patients after listening to the tape involved rating various characteristics of the interviewers and the interview conducted by them. The procedure for the two experimental conditions was identical to that described above except that when the experimental group patients put on the earphones they heard only the two psychiatrist-actors chatting, and were led to believe that the patient hadn't arrived yet. This discussion between the psychiatrist-actors dealt with the rewards to patients for cooperating with the hospital staff, the positive attitudes of the staff toward the patients, etc., i.e., it was our persuasive message designed to be attraction-enhancing.

Our data analyses yielded no significance between condition differences. That is, none of our several change measures of attraction indicated overhearing to be more effective than regular delivery of the persuasive message, nor was the persuasive message effective independent of condition. Our single significant finding was of a positive association across conditions between patient attraction toward the interviewers and independent behavioral ratings obtained from ward nurses of patient cooperativeness.

Perhaps a major conclusion one might draw from the outcome of this investigation relates to the manner in which severe psychopathology quite possibly functions as a limiting parameter on the appropriateness of extrapolatory research of the type we have been examining. Shakow (1963), Buss (1966), McGhie & Chapman (1961) and others, in their investigations of cognitive functioning in schizophrenics (who constituted a large proportion of this study's sample) have demonstrated the difficulty often experienced by such subjects in handling cognitive and perceptual tasks adequately. Processes of overinclusion, interpenetration, perseveration, and associative interference have been identified and may be pointed to by us as a probable basis for the failure of our subjects to receive, process and respond to our persuasive communication in a manner similar to that found by those using normal subjects in the social-psychological laboratory.

The Interview Incident

Robert Deysach, another member of our research group, has conducted

a related study. Rather than attempting to manipulate attraction to the therapist by verbal structuring procedures, as in our first study, or by presenting overheard messages designed to induce attraction, as in our second study, he sought to examine the effects on attraction of overt, therapist behaviors enacted during the course of initial interviews. For this investigation, our specific, social-psychological, extrapolatory base was Adams' cognitive dissonance research on inequitable reward (1961, 1962, 1963). Adams' basic paradigm has involved comparing the productivity of two groups of Ss. Both groups are paid at the same rate for their participation in the experimental procedures. One group is led to feel qualified to earn at the given rate and is thus, from the S's perspective, equitably rewarded. The other group of Ss is led to feel markedly unqualified for the task at hand and, since this group is paid at the same rate, is thus led to feel overcompensated or inequitably rewarded. Adams has consistently found, across a series of productivity criteria, that overcompensated Ss produce significantly more than do equitably Ss - a finding which he has meaningfully explained in terms of the arousal and reduction of cognitive dissonance. Since cognitive dissonance is also reducible by an increased liking for or attraction toward the dissonant position, Deysach included as the core of his design the over-compensated and equitably compensated conditions suggested by Adams' research. More concretely, shortly before the close of the initial interview, with clients assigned to the inequitable reward condition, the therapist picked up his office phone, "called" the clinic secretary and said to her:

Do you people up front have some coffee and donuts today? How about bringing a donut and a cup back here? You don't mind doing me a favor just once, do you? I'll expect to pay you, of course. No, it's not for myself, I just thought I'd like to buy one for (name) Okay, could you check and see how long it will take? (aside to client) I've never tried this before and I think I took her by surprise. I just felt you might like some refreshments, but it ... (to secretary) What? ... How long will it take? ... I guess we'll have to forget about it then. Thanks a lot anyway. (to client) I wish I had called earlier ... now, where were we?

Thus, in this, the inequitable reward condition, the therapist seems to lead the client to believe an attempt has been made to single him out for an admittedly small but perhaps consequential reward and that the procedure is an unusual if not unique therapist behavior instituted in the client's behalf.

Clients in the equitable reward condition were treated identically, save for the fact that the therapist communicated the usualness and

not uniqueness of the reward procedure, i.e., "I've made it a practice with every one of the clients I see to finish our session with some coffee and a donut if I can." Our third experimental group, the reverse reward condition, was like the second in terms of purported usualness of the procedure involved, but in this instance it was made clear that the coffee and donut were for the therapist, and not the client. Finally, we also had a control, or nonreward group for whom no reward procedure intervened during the initial interview.

Our experimental results were unequivocal but surprising. In neither of the conditions in which the client was to be rewarded was there an increment in attraction greater than for our control patients. However, when the therapist was to receive the coffee and donut, patient attraction to him increased to a very marked degree. Why the reverse reward (therapist reward) condition had such a robust maximizing effect on patient attraction we do not know, and can simply offer the speculation that the effect may be related to the possible manner in which the experimental procedure involved enhanced the generalized importance of the therapist in the client's eyes, i.e., a "status-spread effect".

In addition to our criteria of patient attraction, this investigation, paralleling Adams' research, examined dependent variable measures of patient productivity. Our results on these measures were consistent with cognitive dissonance theory. More specifically, inequitably rewarded patients chose to write a significantly greater number of TAT stories than did equitably rewarded patients when told that such stories might help their therapist organize their tests better and that they could respond to as many or as few TAT cards as they wished.

As noted above, we suspect that the relationship-enhancement in Deysach's study may be due to a "status-spread effect". That is, procedures which maximize the therapist's status in the patient's eyes may be causative here. This speculation gains credence from a partially successful replication of Deysach's major findings reported by Roth (1967). Thus, we are currently conducting a therapy-analog investigation in which experimenter status is systematically varied. Since Sanford (1950), Medalia (1955) and others have found that subject authoritarian subjects. "E" conducts a structured, therapylike, interview with all subjects. For half the high and half the low authoritarian Ss, "E" presents himself as an undergraduate doing a senior thesis study. His clothes, office, and general behavior are all consistent with this low status set. The other subjects participate in the same task, with the same "E" who, however, presents himself as a research professor and is dressed, titled, roomed and, in general, behaves in a high status manner. Our usual postinterview relationship measures are obtained. Our major predictions here are that

high interviewer status will be more relationship-enhancing than low interviewer status, and that this effect will be more pronounced for the high authoritarian subjects.

A patient's initial view of his therapist is markedly influenced by information provided by referral sources. In a second current analog investigation, we are examining the relationship implications of such information on the dimensions of therapist warmth and experience. We have developed a "neutral" therapy tape, which subjects listen to and then rate in terms of the attractiveness of the taped therapist. Prior to listening to the tape, however, "S" is given information about the therapist. In this 2 x 2 design, half the Ss are told that the therapist is warm, half that he is business-like and not especially warm. Half are led to believe he has a number of years of therapeutic experience, half that he is a graduate student therapist in training. Our predictions here are straightforward, both warmth and experience referral information should yield relationship-enhancing effects, as well as heightened subjects persuasibility.

We wish to continue this interview incident series of studies further by examining other naturally-occurring psychotherapeutic events (not unlike our coffee and referral incidents) in such a manner that their relationship-enhancing implications are discerned and both their clinical and social psychological relevance established.

Degree of Effort

We are also seeking, in studies currently in progress, to examine a related class of social-psychological research for its psychotherapeutic implications. Specifically, our interest here is in that series of cognitive dissonance studies which have demonstrated that the degree of pretask effort directly influences the level of task attractiveness, such that the greater the effort or difficulty, the greater the increment to attraction. Aronson and Mills (1959), is one of the early studies of this type, examined the effort-attraction relationship under the rubric, "severity of initiation". College women who had volunteered to participate in discussion groups were randomly assigned to one of three experimental conditions: (1) a severe (high effort) initiation to the group, (2) a mild (low effort) initiation, and (3) a control condition. As a precondition to joining the group, the severe-initiation conditions Ss were required of control subjects. Each "S" then listened to a tape recording which appeared to be an ongoing discussion being conducted by the group, and then completed a questionnaire evaluating the discussion and the group members. Results provided clear support for their hypothesis. Ss in the severe initiation conditions perceived the group as being significantly more attractive than did either mild initiation or control subjects.

Zimbardo (1960) reports concurring results. He had 20 university students, all of whom were very much in favor of a numerical grading system, read a report which was a series of arguments against such a grading system. Half of the Ss read the report under high effort conditions, half under low effort conditions. Degree of effort was manipulated, respectively, in terms of a relatively long or a very brief duration of delayed auditory feedback while reading the report. Postreport measurement regarding attitudes toward the grading system revealed that the high effort Ss became significantly more opposed to the numerical grading system than did the low effort Ss. Aiken (1957), Lawrence and Festinger (1962), and Lewis (1964a, 1964b, 1965) have all similarly reported the attraction-enhancing effects of pretask effort, even though effort was operationalized differently in each investigation.

The general theoretical position from which these studies grow, stated simply, is that high effort and low attraction are discrepant or dissonant cognitions. One likely means of dissonance reduction in this context can, and has been demonstrated to be, an increase in attraction. Since psychotherapeutic approaches naturalistically vary in the demands they place upon patients during the candidacy and initial stages of psychotherapy, our current studies seek primarily to test the extrapolatability of this proposition to the psychotherapeutic setting.

In a recently completed study we examined this effort-attraction hypothesis by assigning patients in our clinic to one of three experimental conditions after their initial therapy interview. In the low effort condition the patients simply waited a week and then returned for their second therapy session. Middle effort patients returned to the clinic twice during the week between their first two sessions. Each of these "between session" visits was spent by the patient listening (alone) to the tape recording of his initial therapy session. High effort patients also returned for two interposed tape review sessions. However, prior to the first such review session the experimenter rerecorded the tape of the patient's first therapy session in such a manner that white noise was filtered in, thus making the tape difficult to understand. Our dependent variable measures consisted primarily of instruments assessing the patient's view of the favorableness of his relationship with his therapist. Our results indicated that both high and middle effort patients significantly exceeded low effort patients in the favorableness of their views of the therapy relationship.

The two patient effort studies we are currently conducting are responsive to this first investigation and seek to determine if its findings may be further clarified by recourse to either consolidation or relevance explanations.

Since in our first investigation, patients who heard their first interview tape twice under either high or middle effort conditions became more favorable in their view of their therapy relationship than low effort patients, the effect may have been due to factors other than effort. In a clinical paper using tape review sessions, Gecaris (1960) alludes to a consolidation effect, i.e., the opportunity provided a patient when reviewing a taped therapy session to consolidate gains made, consider therapeutic events more fully, cement any budding insights, etc. To test whether relationship gains made by patients in our first study were due to task effort or consolidation, the following three-condition study was planned:

- A. Consolidation condition - Replicating our previous study's middle effort condition, patients assigned to the consolidation condition return to our clinic twice between their first and second therapy sessions for tape review sessions of their first therapy interview.
- B. Effort condition - These patients also return to the clinic twice between therapy sessions one and two, but the tape they hear is a recorded statement by "E" of the general status and nature of contemporary psychotherapy in United States (From J.D. Frank's "Persuasion and Healing"). Such a tape has apparent relevance to psychotherapy, requires the effort of coming to the clinic twice and listening to tapes, but provides no stimuli for patient consolidation.
- C. Control condition - Patients assigned to this condition are not requested to visit the clinic between therapy sessions.

A comparison of relationship scores by condition should provide information regarding effort versus consolidation as the basis for the relationship-enhancing effect of tape review-sessions.

In our first effort study, the middle effort patients (no white noise) yielded consistently higher mean relationship scores than did high effort (white noise) patients. We are now examining, in a second current effort study, whether the relevance to psychotherapy of the effort put forth by the patient influences its effect on the relationship - since coming to the tape review sessions was perceived by the study patients as relevant to their psychotherapy but the effort due to the white noise was not. Thus, in this investigation effort is held constant but the perceived relevance of the effort to, in the case of this study, the counseling relationship, is varied. This study is being conducted in the vocational counseling section of our Psychological Center. Client effort is operationalized in terms of a battery of cognitive and perceptual tests developed by French (1964).

- A. Effort relevant condition - Prior to their first counseling session, clients are given a one hour battery of these rather difficult tests by the Center's intake personnel. An explicit statement is made to clients in this condition to the effect that such testing is relevant to his counseling, will be seen by his counselor, should be signed, etc.
- B. Effort irrelevant condition - Clients assigned to this condition are treated the same as effort-relevant clients, save that the intaker informs them that the testing is being done under a grant contract, is only for norm collecting purposes, that they need not sign the test forms, the counselor will not see them, etc.
- C. Control condition - No precounseling testing.

Should our prediction that it is relevant effort that maximizes the therapy relationship be sound, condition "A" clients should exceed condition "B" clients on the relationship measures administered after the first and second counseling sessions.

In other studies in this effort relationship series we hope to identify the level at which the effort-relationship association becomes asymptotic, i.e., levels out or decreases. Perhaps of greater consequence, we will wish to learn how far into the course of treatment the relationship-enhancing effect emerged immediately following the effort manipulation (second session) and was even stronger at the point in treatment where we stopped obtaining our relationship measures (fifth session).

The Planted Patient

Our interest in manipulable antecedents and therapeutic consequents of interpersonal attraction has extended beyond the individual psychotherapy setting to the group context. A wealth of social-psychological, group dynamics research has clearly demonstrated the major import for the functioning of nontherapy groups of inter-member attraction (cohesiveness). Thus, members of highly cohesive groups, in contrast to groups in which intermember attraction is low, will: (1) be more open to influence by other group members, (2) be more accepting to member hostility, (3) place greater value on the group's goals, (4) more actively participate in the group's discussion, (5) be less susceptible to disruption as a group when a member terminates, (6) absent themselves less often, and (7) remain in the group longer. In brief, as was true of interpersonal attraction (relationship) in the individual therapy context, interpersonal attraction (cohesiveness) in the small group context appears to be a most consequential variable indeed, one accounting both for much of what transpires in the group as well as much of its success of

whatever its task may be. On the assumption² that cohesiveness is of like importance for the functioning and success of therapy groups, we set out to examine, this time in a less formal research context, one means of influencing intermember attraction in two psychotherapy groups.

One group consisted of seven University students who met at the University's counseling center. The second group, also of seven members, was drawn from an outpatient psychiatric population and met at our county outpatient clinic. Each group was conducted by two therapists, who were advanced graduate students in our clinical psychology training program. Two other graduate students played a very major role in the life of these groups, and it is their contribution I wish to focus upon primarily. To do so, however, it is best that we return momentarily to social-psychological investigations of nontherapy groups. In literally dozens of such studies one notes the use by the investigators of a stooge, accomplice, cohort, shill or plant as an aid in implementing the independent variable manipulation. In much of this group dynamics literature, the plant's role is structured to be attraction-relevant. Thus, the plant may serve as a deviate, one whose stated opinions depart markedly from the group norm. Studies by Emerson (1954), Festinger, et al. (1950), Horowitz, et al. (1951), and several others all demonstrate the intermember attraction will increase in the face of the threat imposed by the deviant plant and, further, will increase even more if they are successful in "winning him over". Other studies (e.g., Gula, 1944) have used accomplices for modeling purposes, and similarly have been able to effect an increase in intermember attraction.

Based upon findings such as these, therefore, we decided to extrapolate from the social-psychological to the group therapy context and proceeded to plant a graduate student as a patient in each of our two groups. Regular planning, role playing and supervisory tape review sessions were combined with the supervisor observing each session as our means of keeping current our impressions of the plant's impact upon his group. We used both these clinical impressions as well as sociometric and attraction-to-group questionnaire data obtained regularly from all group members as our means of both maximizing the plant's potential therapeutic impact upon the group and minimizing the possibility of his true identity being discovered. (neither plant was discovered.)

²But a single study of this proposition has been conducted. Truax (1961) reports significant relationships between cohesiveness in therapy groups and both degree of patient self-exploration and degree of patient insight.

While our use of these plants was not structured as part of a formal investigation, and thus I have little in the form of hard data to report, I would like to share some of our impressions with you in the hope that by doing so we may also be sharing with you our enthusiasm for such extrapolatory attempts. In the opening session or two of each group, when member disclosure anxiety was at a maximum and attraction apparently minimal, our plants (under the guise of having been in a previous therapy group) readily "opened up" and via what clearly appeared to us to be a modeling process, enabled several members of each group to feel comfortable enough to jump in and discuss their own psychopathology. We have not observed such rapid and deep disclosure in other, plantless groups. In later sessions our plants appeared to have a similar attraction-enhancing effect by purposefully serving in the role of opinion deviate, in a manner we have outlined above. We did not, of course, limit ourselves to attempts at cohesiveness enhancement in our use of these plants but, in addition, rehearsed them to play other roles which might serve as protherapeutic group influences. Thus, when needed, they reassured, attacked, befriended, argued, yielded, encouraged, elaborated in detail their own supposed pathology, related in-group to out-group behavior, inspected, as Bach (1954) has termed it, the group's interpersonal traffic, fought the therapists, agreed with the therapists, led the therapists, followed their lead, set the emotional level of the group's going around, psychodramas, eight hour marathon sessions and other structured programs and, perhaps most important from our theoretical perspective, telescoped markedly the time necessary for the group to develop an essentially group-centered mode of functioning.

We made mistakes also, but happily, while some were a bit painful, all proved very far from fatal. Our plants not infrequently and often subtly slid into the role of therapist, an error which was typically corrected by one patient or another interpreting the plants' apparent resistance. Reciprocally, our therapists, on occasion, tended to ignore the plant and endangered his role by failing to give him his "fair share" of treatment time. Again, other patients tended to correct this error. At times our plants failed to behave in a manner consistent with their stated psychopathology and, again, were typically called on it by a sensitive patient. Thus, the plant in our student group supposedly found it difficult to get close to people and, in other ways, purported to suffer from marked interpersonal insensitivity. The night he made exquisitely sensitive observations about other patients' interpersonal behavior has come to be known by us as the night the plant became a weed. Finally, at times a language problem emerged, a problem we might label "jargon in everyday life". Have you ever heard a supposedly unsophisticated group therapy patient, in the midst of an argument about the degree to which the group agrees on a particularly salient

issue, use the term "consensual validation?"³

It is most important with regard to both our use of these planted patients as well as the attraction-induction procedures we utilized in the studies discussed above, that we consider the ethical questions characteristically raised in response to the high manipulative, risk-taking component of these procedures. In doing so, I wish to take the liberty of quoting a statement made by us elsewhere (Goldstein, et al. 1966) in developing an extrapolatory research approach more fully:

Manipulative approaches may be attacked on the ground that they dehumanize, treat the patient as a machine or object or, more generally, that they reflect a nonhumanitarian orientation to sick or unhappy people. Our position, quite the contrary, is that current psychotherapeutic approaches are deficient on a humanitarianism continuum largely because they do not incorporate or reflect research findings regarding the most effective means of altering an individual's behavior - the very reason for the existence of psychotherapy. To know that solid research dealing with attitude change, learning, group dynamics and a score of other domains offering other manipulative means of altering an individual's behavior exists, and to deny in an a priori manner the potential relevance of such research to the psychotherapy patient is to perform a disservice to both the advance of psychotherapy and to one's psychotherapy patients. Obviously, there will be limits that society will impose upon its psychological practitioners. But to imply that these limits can be imposed without evidence, without research on behavior control, is to deny the experimental foundation on which science rests. We have an obligation to society and to our psychotherapy patients, and this obligation demands that we publicize and use the best possible scientific findings in our own field. To do less than this, we hold, is a failure to meet our ethical responsibilities. (Pp 8-9)

³See Goldstein, et al. (in press) for a more extended discussion of the use of plants in group psychotherapy.

Summary

We have sought to outline here the beginnings of an extrapolatory research program. While some aspects of the psychotherapeutic relationship viewed in interpersonal attraction terms have been clarified by our results, we have perhaps learned more thus far about the conditions under which extrapolation from social-psychology to psychotherapy is inappropriate than where it is. But a beginning it is. Social-psychology's contribution to the psychology of behavior change is broad indeed. It is far from inappropriate for us to both hope and expect that as the terrain involved here becomes more familiar to both us and to others, important contributions to the advance of psychotherapy will emerge.

References

- Adams, J.S. The measurement of perceived equity in pay differentials. Unpublished manuscript, Behavior Research Service, General Electric Co., 1961.
- Adams, J. S. Toward an understanding to inequity. J. abnorm. soc. Psychol., 1963, 67, 422-436.
- Adams, J. S. and Rosenbaum, W. B. The relationship of worker productivity to cognitive dissonance. J. appl. Psychol., 1962, 46, 161-164.
- Aiken, E. G. The effort variable in the acquisition, extinction and spontaneous recovery of an instrumental response. J. exp. Psychol., 1957, 53, 47-51
- Aronson, E. and Mills, J. The effects of severity of initiation on liking for a group. J. abnorm. soc. Psychol., 1959, 59, 177-181.
- Ashby, J. D., Ford, D. H., Guernsey, B. G. and Guernsey, L. F. Effects on clients of a reflective and a leading type of psychotherapy. Psychol. Monogr., 1957, 71, Whole No. 453.
- Bach, G. R. Intensive group psychotherapy. New York: Ronald Press, 1954.
- Back, K. W. Influence through social communication. J. abnorm. soc. Psychol., 1951, 46, 9-23.
- Bown, O. H. An investigation of therapeutic relationships in client-centered psychotherapy. Unpublished doctoral dissertation, University of Chicago, 1954.
- Bordin, E. S. Inside the therapeutic hour. In E. A. Rubinstein and M. B. Parloff (Eds.) Research in psychotherapy. Washington: American Psychological Association, 1959, Pp. 235-246.
- Brock, T. C. and Becker, L. A. Ineffectiveness of "overheard" counter propaganda. J. pers. soc. Psychol., 1965, 2, 654-660.
- Burdick, H. A. and Burnes, A. J. A test of the "strain toward symmetry" theories. J. abnorm. soc. Psychol., 1958, 57, 367-370.
- Buss, A. Psychopathology. New York: John Wiley, 1966.

- Emerson, R. M. Deviation and rejection: an experimental replication. Amer. soc. Rev., 1954, 19, 688-693.
- Festinger, L. A theory of cognitive dissonance. Stanford University Press, 1957.
- Festinger, L., Schacter, S. and Back, K. Social pressures in informal groups. New York: Harper, 1950.
- French, T. R. Reference kit for cognitive and perceptual tests. Princeton, New Jersey: Educational Testing Service, 1964.
- Geocariss, K. The patient as listener. Arch. gen. Psychiat., 1960, 2, 81-88.
- Gerard, H. B. The anchorage of opinions in face-to-face groups. Hum. Relat., 1954, 7, 313-325.
- Goldstein, A. P., Heller, K. and Sechrest, L. B. Psychotherapy and the psychology of behavior change. New York: John Wiley, 1966.
- Goldstein, A. P., Gassner, S. M., Greenberg, R., Gustin, A., Land, J., Lieberman, B., and Streiner, D. The use of planted patients in group psychotherapy. Amer. J. Psychother., in press.
- Gordon, R. L. Interaction between attitude and the definitions of the situation in the expression of opinion. Amer. social Rev., 1952, 17, 50-58.
- Grinker, R. R. A transactional model for psychotherapy. In M. J. Stein (Ed.) Contemporary psychotherapies. New York: Free Press, 1961, Pp. 190-213.
- Gula, M. Boy's house - the use of a group for observation and treatment. Ment. Hyg., 1944, 28, 430-437.
- Heider, J. The psychology of interpersonal relations. New York: John Wiley, 1958.
- Holt, R. R. and Luborsky, L. Research in the selection of psychiatrists. Bull. Menninger Clin., 1952, 16, 125-135.
- Horowitz, M. W., Lyons, J. and Perlmutter, H. V. Induction of forces in discussion groups. Hum. Relat., 1951, 4, 57-75.

- Hunt, J. McV., Ewing, T. N., LaForge, R. and Gilbert, W. M. An integrated approach to research on therapeutic counseling with samples of results. J. counsel. Psychol., 1959, 6, 46-54.
- Jackson, D. D. Interactional psychotherapy. In M. I. Stein (Ed.). Contemporary psychotherapies. New York: Free Press, 1961, Pp. 256-271.
- Jones, E. E. and Thibaut, J. W. Interaction goals as bases of inference in interpersonal perception. In R. Taguiri and L. Petrullo (Eds.). Person perception and interpersonal behavior. Stanford: Stanford University Press, 1962.
- Lawrence, D. H. and Festinger, L. Deterrents and reinforcements. Stanford: Stanford University Press, 1962.
- Lewis, M. The effect of effort on value: An exploratory study of children. Child Devel., 1964, 35, 1337-1342(a).
- Lewis, M. Some nondecremental effects of effort. J. compar. physio. Psychol., 1964, 55, 367-372(b).
- Lewis, M. The effect of effort on choice: The value of a secondary reinforcer. Psychol. Rpts., 1965, 16, 557-560.
- Mahl, G. F. Disturbances and silences in the patient's speech in psychotherapy. J. abnorm. soc. Psychol., 1956, 53, 1-15.
- McGhie, A. and Chapman, J. Disorders of attention and perception in early schizophrenia. Brit. J. med. Psychol., 1961, 34, 103-116.
- Medalia, N. Z. Authoritarianism, leader acceptance, and group cohesion. J. abnorm. soc. Psychol., 1955, 51, 207-213.
- Newcomb, T. M. Personality and social change: Attitude formation in a student community. New York: Dryden, 1943.
- Osgood, C. E. and Tannenbaum, P. H. The principle of congruity in the prediction of attitude change. Psychol. Rev., 1955, 62, 42-55.
- Parloff, M. B. Therapist-patient relationship and outcome of psychotherapy. J. consult. Psychol., 1961, 25, 29-38.
- Rasmussen, G. and Zanker, A. Group membership and self-evaluation. Hum. Relat., 1954, 7, 239-251.
- Rogers, C. R. The characteristics of a helping relationship. In M. I. Stein (Ed.) Contemporary psychotherapies. New York: Free Press, 1961, Pp. 95-112.

- Roth, C. The effects of psychological reactance on interpersonal attraction on a quasi-psychodiagnostic task. Senior honors thesis, Syracuse University, 1967.
- Sanford, F. H. Authoritarianism and leadership. Phila.: Inst. for research in human relat., 1950.
- Sapolsky, A. Effect of interpersonal relationships upon verbal conditioning. J. abnorm. soc. Psychol., 1960, 60, 241-246.
- Seashore, S. E. Group cohesiveness as a factor in industrial morale and productivity. Amer. Psychologist, 1954, 9, 468.
- Shakow, D. Psychological deficit in schizophrenia. Behav. Sci., 1963, 8, 275-305.
- Snyder, W. U. The psychotherapy relationship. New York: Macmillan, 1961.
- Truax, C. B. The process of group psychotherapy. Psychol. Monogr., 1961, 75, Whole No. 511.
- Van der Veen, F. Effects of the therapist and the patient on each other's therapeutic behavior. J. consult. Psychol., 1965, 29, 19-26.
- Walster, E. and Festinger, L. The effectiveness of "overheard" persuasive communications. J. abnorm. soc. Psychol., 1962, 65, 395-402.
- Wolberg, L. R. The technique of psychotherapy. New York: Grune and Stratton, 1954.
- Zimbardo, P. G. Involvement and communication discrepancy as determinants of opinion change. J. abnorm. soc. Psychol., 1960, 60, 86-94.

Experimental Social Innovation in Mental Illness

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While recidivism and chronic hospitalization are the foremost problems in mental hospital treatment today, a moment's reflection upon the daily work with mental patients by those of you who work with this marginal group, should demonstrate to you that those persons who remain in the hospital can and do establish and maintain a particular role in the treatment setting. However psychotic he may be, each patient becomes defined as a certain person within the hospital. He may act as a clown, an isolate, a leader, or a follower. But, regardless of his role definition, his behavior gives him a known social position which provides him and others with an expected set of behaviors. Once he has established a role, it is extremely difficult for the mental patient to leave the institution and attempt an adjustment in the community. This is true because his well-defined hospital role does not exist in the community. Upon returning to the community he must relinquish the recognized social position that he has so slowly and painstakingly developed in the hospital. And, in addition, he becomes a member of a feared minority group, the exmental patient group. As an exmental patient, he is discriminated against by the people in the community even while attempting to establish a new social role for himself - a task he has failed to perform in the past. Why then should he give up the hospital role in which he has gained a degree of social prestige for a community role where he will be feared and perhaps hated. Under these conditions it is no wonder that when the chronic psychotic patient leaves the hospital, he typically quickly returns. Indeed, it is a wonder that he leaves at all. It seems necessary now to take a new look at how the chronic mental patient can make a transition to the community without losing the stabilizing influence of the social position he has had in the hospital.

Today I will be reporting on two longitudinal studies conducted by Dr. George W. Fairweather and his research group, of whom I am one. The first pertains to a hospital treatment program and the second to a community treatment program. The initial research reported is a hospital program in which techniques were developed for organizing patient groups containing mostly chronic psychotics. This research has been pointed towards solving the problem of the high rate of recidivism of previously hospitalized mental patients, particularly chronic institutionalized psychotics.

Despite the fact that a large body of literature maintained that psychotics could not solve problems because of their autism and withdrawn behavior, Fairweather's early studies with small groups of psychotic patients led him to ask two major questions in 1961. They were: 1) Can small problem-solving groups of hospitalized

psychotic patients be formed? 2) Can the group members take care of and maintain each other? In other words, could groups, in which the members would become so dependent upon one another as to provide stabilization or support for their members, exceed the support which was unavailable to the individuals themselves? A study to explore answers to these questions established a small-group treatment program and compared it to a traditional treatment program. It clearly showed that problem-solving groups of patients could be formed and that they could take care of each other. Further, these groups of mental patients demonstrated many of the characteristics of small groups in other decision-making situations.

Throughout this research, the meaningful task has involved the current living and future planning for each member of a group. A step level system delineates for the patients, and the staff as well, the task the groups are rewarded for accomplishing. A simple system of rewards and punishments is associated with the performance of the task groups. Each patient is assigned to a task group upon his arrival on the ward, and remains in this group until he leaves. Each group member must go through four steps in order to successfully complete the program and the group is responsible, as a unit, for each of its individual members. Scrutiny of the step system shows that the rewards increase with the level of responsibility of the task. The first step is that of personal care, punctuality on assignments, and orientation of new members. When, in this step, the member receives \$10 and a one-day pass per week. Step 2 involves adequate performance in Step 1, as well as qualitatively acceptable work on job assignments. In Step 2, the member receives \$15 per week and two one-day passes per week. In Step 3, members are now responsible for Steps 1 and 2 and, in addition, recommend their own money and passes commensurate with individual step level. In Step 3, members are eligible for \$20 per week and an overnight pass. In Step 4, the member is responsible for posthospital plans and is entitled to a weekend pass and \$25 plus per week. In order to provide forces for cohesion, the task groups are responsible, as units, for the performance of their members, since a meaningful task and rewards alone might not produce the desired cohesiveness, where each patient is concerned about every other patient of his group. In view of the fact that it seemed somewhat unrealistic to require that the group be responsible for the behavior of members which it might not be able to control, the determining feature of rewards and punishments is the recommendations of the task groups to the staff. Thus, it is the reality of the task group's recommendations which are rewarded and punished. This permits the staff to make the final decisions by determining the validity of the task group's recommendations. Thus, the staff maintains control of the ward and at the same time allows the patients maximum opportunity for responsible and realistic decision-making behavior.

The task group meets daily by themselves four days of the week and on the fifth day meets with the staff to present the evaluation of their group. The group's secretary verbally presents a written account of the week's decisions regarding problems presented to the group by the staff. Daily problems are communicated to the group by the staff by means of a note system. A note is written to a group for each such problem or for relating information to the group and is signed by the staff member calling it to the attention of the group. The evaluation usually includes recommendations about the progress in step level, money and passes, departure planning, and job performance for each member of the group, as well as an evaluation of the general level of the group's performance. At the completion of the group's formal presentation, the staff retires to a separate room. The staff then reviews the group's solutions to all of its problems during the week as to their reality and appropriateness of the recommended solutions and the responsibility the group is taking for its members. A record of the notes given to the group during the week is kept by the staff and a decision is expected on each note. The staff then discusses the step level recommendations of the group and approves or disapproves them, at which time the staff reports back to the group its evaluation of the group. When a group has not functioned well, demonstrated poor problem solution, overall poor performance, and/or disorganization, the entire group is reduced in step level or the members are frozen in their current step levels, dependent upon the severity of the group's poor performance. During the task group meeting hour, the entire staff is on consultation call and can be summoned to any group to present factual information in order for the group to arrive at a reasonable decision. It is noted that the staff cannot make a decision for the group or any of its members, but can present factual information requested by the group. If a task group member approaches a staff member to solve a problem, he is referred back to his group for solution of the problem and a note is sent to his group informing them of his improper behavior. This deviant behavior is in effect an attempt to take from the group their responsibility, authority, and autonomy.

As previously mentioned, the groups of patients in the small-group program meet daily during the week to transact their assigned business. The meetings are carried on without any member of the hospital staff present and the groups must reach some decision on each of the problems presented to it. These problems range from what to do about a member who never gets to his appointments to helping a group member plan for his release from the hospital. The decisions made by the group on each matter are forwarded to the ward staff as a recommended course of action. The ward staff reserves, at all times, the right to disapprove the group's recommendations and to return the problem to the group for another solution.

This monitoring by the staff is done on all but a few minor areas of the group's responsibilities and culminates in the previously mentioned weekly evaluation of the group by the staff. At this evaluation, the group receives feedback of both information and reward-punishment from the staff for its overall performance during the week.

Staff supervision is necessary because it involves an important aspect of the program. The group must be monitored because its activities are not limited to verbal behavior. It does not simply discuss things, but must actually deal with problems of living as they arise in the behavior of its members and must make decisions on what to do about them. These decisions are expected to be realistic enough to be acted upon, and the group is evaluated by the staff on its ability to show good judgment in dealing with the problems which arise. This means that the group must learn effective methods of dealing with behavior problems, and must accept the responsibility for the behavior of its members - even to the point of planning for release from the hospital. It must learn to punish or reward its members when necessary, to provide help or instruction as needed, and to show acceptable judgment in handling a wide variety of problems. Most elements of the small-group treatment program are concerned with generating and maintaining the exact degree of autonomy control which will elicit such problem-solving behaviors from groups of chronic mental patients in a hospital setting. Let us look at some of the ingredients.

First of all, there is the system of communication. All information passing between the staff and the group takes place through written notes which are placed in designated mailboxes on the ward. The groups receive all their problems by these notes as well as most information, and they send their responses to the ward staff by return mail. Three features of this system are important:

- 1) Except for emergencies, the ward staff responds to the behavior problem of a group member by writing the group a note and awaiting the group's recommendation. It does not take direct action.
- 2) The notes to the group are factual and as nonevaluative as possible; it is the group's responsibility to decide if action is warranted and then to recommend such action to the staff.
- 3) The emphasis is on behavior and not on inferred psychological states. If a group member is absent from his assignment, this is reported to his group; the fact that he also appears confused is irrelevant.

Second, no staff member ever enters a group meeting except when requested to do so by the group, and then is restricted to one of two behaviors: giving information which the group would not be expected to have, or providing support situations which the group cannot handle. This last function is restricted to emergencies and is almost always in response to the group's request. Generally,

it is not a good idea for the staff to respond to shouts and heated language from the group meeting rooms because this usually means that a good meeting is in progress, and nothing more.

Third is the weekly evaluation meeting, when the staff meets with each group to review its entire performance for the past week. After the group presents its minutes for the week and each member gives a personal comment, the staff retires to prepare a written evaluation of the group's performance. The group receives a copy of this evaluation and, on the basis of it, the staff rewards or punishes the group, as a whole, for its performance by the amount of weekly cash or pass time which the members may have for that week. Each member is recommended by his group for one of four "step levels" in the program based upon his behavior in the past week. The step levels have different pass and money privileges associated with them and the staff may approve or disapprove such recommendations. The "step level" recommendations are themselves evaluated as an example of the group's judgment.

These are the main components of the experimental program. Integrated into it are the conditions which five studies, over the past few years, have shown to be crucial to the formation of cohesive task groups of chronic patients at Palo Alto. I will list those conditions.

1. The groups must be "autonomous" in the sense that they must solve problems and make decisions with no staff present. The presence of a staff member is destructive to the group's cohesiveness since it tends to inhibit discussion and destroy patient leadership. Given the opportunity, the group will gladly defer all decisions to the staff.
2. A communication system must be maintained which allows the staff to present the group with problems without involving the staff in group decisions. This is the purpose of the written notes and evaluations in the program.
3. The task set the groups must be a meaningful one. In this case, it is solving behavioral problems of group members, managing the day-to-day living and working on the ward and planning for discharge.
4. A system of rewards and punishments must be available to the staff for shaping the group's performance. Without this, the staff cannot change the group's behavior when it is drifting into indolent and maladaptive ways, and groups will not improve in

performance without rewards. In a hospital, weekly cash allowance and pass time are obvious and meaningful rewards and these are used in the program.

5. The rewards and punishments must be applied to the group, as a whole, since only in this way can it be preserved as a cohesive unit.

These conditions seem to be minimal for maintaining the kind of task groups I have described in a mental hospital environment.

In describing the small-group program, I have mainly spoken of the mechanics of the system. It is, therefore, appropriate to discuss another important component of the program - the ward staff. One prior study has shown that, with proper training and preparation, staff may be completely replaced without altering the program to any appreciable degree. This points up an important fact: the formal structure of the experimental program is as much for the control of the staff behavior as it is for the shaping of patient performance. A staff that fails to grasp this, that fails to see it (no less than the patients) is bound by the "rules of the game" on the ward and will almost invariably destroy group cohesion and effectiveness.

Perhaps it is especially difficult for a hospital staff to control its behavior in this way. It is hard for some personnel to accept the new role of the "patient" in this sort of program. The medical model of the healer and patient roles is violated by the notion that the "patients" generate their own therapeutic social environment, and that they are responsible for their own behavior and that of their fellows. In this respect, chronic mental hospital patients are generally as well trained as the staff. They are thoroughly conditioned to the "sick" role and will try, in countless and devious ways, to persuade, cajole or trick the staff into resuming responsibility and decision making. If the staff does this, it is fatal to the group's cohesion. An explicit program, with explicit rules of procedure and ward regulations, makes it much easier for the staff to control its own processes and to resist tendencies to violate group autonomy.

However, let me quickly add that these remarks do not mean that the rules of operation are inflexible. Changes are made in the program all the time. The important thing is that such changes are always made in one of two ways. In the first way, the change is made on an experimental basis and controlled observations made of the results on the groups. This allows a meaningful evaluation of its effects. In cases where a problem arises which makes a minor change in ward rules necessary, the staff refrains from simply

writing a new regulation. Instead, the problem is presented to the patients' community meeting and it is requested to find a solution and send a recommendation to the staff. Such recommendations are evaluated by the staff and either adopted or the problem returned to the group. In many instances, problems are both raised and solved by the patient group on its own initiative.

The results of this initial longitudinal study showed that the patients in the small-group program demonstrated higher social activity in all situations with increased self-involvement of the most chronic patients. Their expectancies about the future were brighter and they perceived the increased responsibilities required by the program as difficult but rewarding. The small-group patients manifested a pronounced personal involvement in the adjustment of other members of their group; they showed higher morale; and more frequently perceived their fellows as socially desirable. Posthospital adjustment by members of the small-group program was better with regard to employment and social adjustment in the community than that of the members of the traditional program, which was less socially active and more time consuming. Furthermore, many of the most chronic small-group patients were active program participants and some became group leaders. In its unique role as an evaluation team, the staff itself became a cohesive group and its morale and interest were heightened as a result of change in the patient-groups' behavior. All of the above results obtained while significantly shortening the time patients spent in the hospital.

Despite the success and considerable advantages of the small-group approach, as contrasted with the traditional treatment program, 16.67% of psychotics with over two years' previous hospitalization never left the hospital during the initial year. Moreover, 35.42% of the chronics who left returned to the hospital within six months. Consequently, 52.09% of this population was in the hospital at the termination of the six month follow-up period.

As revealing as the above statistics are, the results pertaining to posthospital employment focus on possibly the paramount problem that must be faced by not only the chronic mental patient, but also by all chronic marginal individuals. Only 24% of the entire research sample was employed full time during some period of the six month follow-up. While 7% was employed approximately half-time and 16% about quarter-time for some period during the six months, a fantastic 53% was totally unemployed. In the overall sample, the average number of days employed as 53 out of 183 possible days. In other words, only an average of 28% of the possible work time was utilized. This occurred despite the fact that the progressive social system of the small-group program led to a significant difference between the experimental and control groups regarding the number employed.

Further analyses of the data showed that the posthospital adjustment of patients who remain out of the hospital the longest are those who have a socially supportive living situation in the community and are more frequently employed, but specifically in a low status job. These are also the patients who are more communicative with other people. This is probably the most profound and significant result of the study, for it cannot go unnoticed that posthospital adjustment correlates with no significant hospital behavior but it is highly related to the posthospital situation to which the patient returns.

The results of this study, published in the book "SOCIAL PSYCHOLOGY IN TREATING MENTAL ILLNESS: AN EXPERIMENTAL APPROACH", indicated that a new approach aimed at reestablishing chronic mental patients in the community was in order. The characteristics of such a new program are described in that book in the following manner:

"Such an approach needs to create patient role behaviors within the hospital that are consistent with those of community living. Furthermore, a mechanism to bridge the gap between the protective hospital setting with its minimal demands and the more rigorous demands of community life needs to be found. This is particularly important since, not only must the patient make the transition from a protective living situation but he must also be supported in some measure against the rejecting attitudes of some members of his society who will regard him as a member of a feared minority group - the mentally ill.

"A rapprochement between the role requirements of hospital and community membership might conceivably be brought about by establishing reference groups within the hospital who would return as units to the community."

Evidence regarding the patients' community adjustment obtained from the small-group study just mentioned, highlighted the fact that the community must be the center of future treatment programs. To be feasible such programs would have to be undertaken with a minimum of professional assistance.

As an outgrowth of the small-group study, the decision was made to examine experimentally the proposition that task groups, trained in decision-making in the hospital, could be moved into the community as units. The belief was that such groups would maintain each person's status and role that had been established in the hospital, thus, giving him a stable membership in a social system. The entire social system could then be implanted in the community. To discover whether small groups could be organized and moved as units into the community in order to reduce recidivism and unemployment, Fairweather and his research group applied for a large-scale grant. This provided funds for the planning and execution of the community study that I will now describe.

The goal of this research was to provide a total social subsystem for the rehabilitation of chronic psychotics and to contrast it with an existing hospital small-group treatment program on reduction in the recidivism rate, self-enhancement, and the degree to which hospitalization was reduced.

One program attempted to establish a community lodge which is an extension of a supportive group social system developed within the hospital while the comparative program used the same system in the hospital but afforded traditional types of community assistance following release from the hospital, such as outpatient treatment prescribed by the ward staff, and the like. Both had the same hospital treatment program. Patients participated in three rehabilitation programs or experimental groups, namely: 1) Volunteer chronic patients who lived in a community lodge after release from the hospital; 2) Volunteer chronic patients who either returned to other community situations or remained in the hospital, this being the volunteer control group and 3) Nonvolunteer chronic patients who either returned to other community situations or remained in the hospital, this being the nonvolunteer control group.

The plan was to organize a task group in the hospital which could then be moved into a community lodge. In the hospital, this group was early presented with problems that they would have to face once they arrived in the community. Such problems as how to organize the lodge and how to purchase and prepare food were discussed and solved by the members of the group. The idea was to train the group in problem solving behavior while they were in the hospital so that they could behave independently once they arrived in the community. It was hoped that the problem-solving ability acquired by the group during this training period would help them solve the problems they would soon face in the community.

After four weeks of such training, the group moved from the hospital into a motel which had been leased as living quarters. The first evidence that our training program had been a failure occurred at this point. All of the problem-solving ability so assiduously developed in the hospital disappeared. Rather than going about the tasks of preparing food and training members for work that had been developed in the hospital, all of the members gathered around the kitchen. The person who had claimed that he was a cook, couldn't cook. The food that was supposed to have been purchased for the meals had only been partially obtained. And what we, as experimenters, learned at this point was that our earlier work which showed no relationship between hospital and community behaviors had indeed been very accurate. But, of course, this lack of problem-solving behavior was accompanied by a variety of humorous incidents.

During the first day, while most of the people were milling about the kitchen, the leader of the group and his sidekick disappeared.

They could not be found anywhere around the lodge site. About two hours later they reappeared. The leader, who wore a baseball hat askew on his head, said, "We have just bought the land next door for a recreation area. We are going to build a bridge over the freeway and put in swimming pools and a playground." When he was asked what they would do for money he said, that since we were from a major university he was certain the university could dig up the money for this venture. A carnival atmosphere prevailed. It was unlike anything we had witnessed before. The members acted as if they had been recently freed from a prison and they were bent upon enjoying themselves while the freedom lasted. They began habituating a cocktail bar and became quite well known as "play-boys" in the first week of their stay in the community. During that week we learned about medication, too; without our knowledge, one individual quit taking his medication. After about a week, he began setting small fires along a freeway fence. He had to be returned to the hospital. This first behavior problem had a marked sobering impact upon the lodge members for they suddenly became aware of what might happen when their fellow members did not take their medication. And so, the first of a series of rules governing the behavior of lodge members was established. This rule required members to take their medication and if they did not, the business manager, a lodge member himself, would see that their medication was given to them. For the remainder of the four years of our contact with the lodge there were no further difficulties with medication that could not be handled by the lodge members themselves. Another problem that very quickly became defined was that the members did not know how to work by standards that were acceptable in the community. Even though several of them had worked for years in the janitorial service of the hospital, and one had even been a member employee there, their work methods were shoddy and disorganized. Despite this, the group wanted immediately to go to work in the community. So, after some brief training sessions, work began. Advertisements were placed in the local paper and telephone calls were received requesting job estimates from the janitorial service.

The first job the group had to do was for a member of the professional staff of the hospital. Here we discovered again some of the unrealistic behavior that comes from years of divorce from the community. According to the training procedures, the leader of the group was to make the job bid. He walked through the house with the professional person and his wife. They showed him the various areas that needed cleaning. Then they went to the living room and sat down and the leader, with his hat askew and pacing up and down the living room, was asked by the owner of the house how much the job would cost. And, without a flicker of a smile he said, "I think we can let you have it for \$1,000." This led to further evidence that training within the hospital had not had the result we had hoped it would. Furthermore, it became clear that a staff member would have to make the job bids if we were to remain in business.

Then we lost our second and third jobs. The first reaction of the group to losing these two jobs was that people in the community would never stop discriminating against exmental patients. But, after several hours of cathartic negativism, a more positive attitude began to emerge and that involved a reassessment of their failures and some concern about, "What are we doing wrong for which we are getting fired". With this reassessment and questioning of the value of their work, a training program was put into effect. This training program, unlike the first one, began to show signs of success mainly because the workers were now willing to find out how they might better do their job.

It is important here to review briefly what these first few weeks had accomplished.

1. A social organization was beginning to take shape.
2. In the beginning phases of any new social organization established in the community some social organization has to be imposed by the staff regardless of how much autonomy one wishes to give the members.
3. It became very clear that behavior changed as a direct result of negative feedback from the community. It was only after they had failed in the real life setting that they were eventually willing to take a look at their own behavior and to question its value.

As time passed, a more well-defined social organization began taking shape. Various members were assigned to positions of responsibility. One individual took over responsibility for the kitchen. He purchased all the food, planned and cooked the meals. He eventually became an excellent cook as evidenced by the fact that delivery men who had the lodge on their route frequently arranged their time so that they could spend their lunch hour or leisure time at the lodge. They often stated that the lodge was the most friendly place on their route.

A business manager was appointed and work leaders emerged. And most important, a committee of lodge members was formed to make decisions about the management of the lodge. This committee was designated the executive committee and among other management functions, it had the authority to discipline the members. It played the legislative, judicial, and police roles in this small neophyte society. The work performance of the members began to improve. We found that the members performed best in crews and usually in crews comprised of three people. The person that was responsible for the crew was given the title of crew chief, the next most responsible person was the worker, and the third individual on the crew was a "Nebbish". Nebbish is a word which

means "nothing" in Yiddish and this work became adopted in the lodge because one of the supervisors in a fit of disgust once told a worker, "You are a Nebbish". He then explained to the group what Nebbish meant and this word was then adopted by the lodge members. This working arrangement was quite satisfactory. It was particularly good for the poorer workers who, by this technique, always had a role on a crew.

And, this leads to some statements about the symptoms that these chronic patients had. Throughout their stay at the lodge, they never became completely devoid of symptoms. It was necessary for most people to remain on medication but what happened was that the members became aware of the places in which their behavior was least acceptable. For example, they rarely hallucinated or deluded on work assignments. Let me deviate for a moment to tell you how this worked. One member continuously hallucinated. This was the cause for a great deal of concern by other members when working in a residence or a business where they might be observed. Accordingly, the supervisor of his work crew informed the hallucinated individual that if he hallucinated on the job he would sock him. Henceforth, little hallucinating was done on the job although he did hallucinate in the truck while driving to the job, and, as soon as the job was finished, he began hallucinating in the truck once they left the work area. This is an important point because among their peers, symptoms were readily accepted. Around the lodge, for example, it was quite permissible to exhibit odd behavior because you were accepted as a person regardless of how you behaved. However, when you were in situations, other than at the lodge or among your peers, it was important to behave in more normative ways so that you did not bring shame upon the organization. This was a very important aspect of the lodge society. Individuals were not asked to give up totally their symptoms but rather to learn where such behavior was appropriate and where it was inappropriate and to behave accordingly.

As time passed, the organization became well thought of and a pillar of strength in the community. It was initially located at the edge of a Negro ghetto where considerable maladaptive behavior often occurred. We were an integrated group and soon became known as such in the area. We were viewed as responsible people by both the black and white individuals in the neighborhood. Several times people came to our group asking for employment. And, on one occasion, the members saved the life of a service station attendant. The service station, located next door to the lodge, was robbed one evening and the attendant was stabbed in the neck. It was only through quick emergency activity on the part of the lodge members that his life was saved. And you might be interested to know that their behavior was usually approved by individuals with whom they had daily contact. For example, the physician whose office they

visited and who treated each member as any outpatient was continuously surprised at these individuals' morale and their interest in the lodge. The physician had had several years experience with chronic mental patients prior to entering private practice and he perceived this group as making the most adequate adjustment possible for such individuals.

But, along with these successes, and particularly the success in work, came additional problems. When the lodge was first organized, the worst possible thing one could do was to return to the hospital. This was an unacceptable form of behavior. Very often individuals would beg members not to return to the hospital by telling them that once they returned they had lost their last chance to again become first class citizens. But as the business became more and more successful, the leaders of the group began concentrating more and more upon the business aspects of the lodge and less and less upon the rehabilitative aspects. Thus, there emerged a new value - the "work-business" value. This value eventually came in conflict with the "rehabilitative" value. As time went on, there was less and less tolerance for the marginal worker. He was often fined for failing to appear for work or working poorly. Eventually, the work norm took preeminence over the rehabilitative norm and when this happened there developed what we called the "revolt of the Nebbishes". The marginal workers united and petitioned the executive committee of the lodge for a vote in the decision making process of the lodge. The consultant to the lodge by this time had relinquished most of his authority to the group but he still retained the power of veto over decisions made by the executive committee. The executive committee decided to ignore the petition of the marginal workers. The consultant vetoed this decision and further rules that the marginal workers should now become part of the executive committee so that all matters should be decided in the future by a majority vote of all the members. It is interesting to note here that after this action was taken, the marginal workers soon lost interest in the organization and the executive committee again controlled the organization. It was as if the rebellion was concerned not so much with participating in the decision-making process but rather the right to vote if one wished to do so.

There was another matter which was of deep concern to all of us, and I believe to all of you present here. That was the negativism with which the members of the lodge viewed professional mental health workers. Shortly after our arrival in the community, the hospital director, knowing that we were hard pressed for employment, offered the group an opportunity to do some contract work for the hospital by keeping up the hospital grounds. This offer was immediately rejected by the group. Their logic was, that if they returned to the hospital grounds, they would be perceived as patients and, hence, put in an inferior social position. They often expressed the feeling that mental health workers are generally unable to view as equals

people who have been hospitalized with a mental illness. The accuracy of this perception was demonstrated over and over again as the project progressed. I will select a dramatic example to illustrate this point. One day a crew went to work in a nurse's house. Throughout their 3 to 4 hours of work there, she appeared on the scene several times always with some excuse for returning to the house. The work crew was quite certain that she was there to supervise their work and check on their progress. To them, this meant that she did not really trust them. By contrast, they worked shortly thereafter for a contractor who had just built a 62 unit apartment building. He handed the keys of the apartments to the crew chief and told him to call the contractor when the work was completed. The contractor did not check on their performance until they had completed the work. This demonstrated to them that he believed they could do the assigned work. It was this form of trust which over and over again was shown by people who were not involved in the mental health field but not by those who were so involved. To illustrate how strongly this affected the lodge members, it is noted here that when they reached a stage where they had done their last job for people from the mental health field, they threw a party to celebrate this occasion. They were now free.

As you may have guessed, the lodge moved successively towards autonomy. The first supervisor of the lodge was a psychologist with many years experience in working with mental patients. As mentioned earlier, he created a rather structured social situation for the first few months of the lodge. A second more autonomous phase was created when a graduate student took over the reins of lodge consultant. He gave more autonomy to the members and gradually the idea began to take shape that lay leaders might be able to do the job even better than professionals. And so we approached the State Bureau of Employment and selected two individuals at random to take over the lodge. One was a man in his early 60's who had been a former salesman for a large department store and a second was a former marble worker who had sustained a back injury and had to leave his trade. To everyone's surprise, morale showed a rapid upswing once the graduate student had gone. Work increased and it was thus found that motivated and interested lay persons can serve as adequate leaders for such community programs.

Eventually, the experiment was ending and it became necessary at this point to discover whether the members could assume full responsibility for themselves. On a prearranged date, the lodge members were informed that gradually over the next several months, the amount of money contributed to their support for food, medication, and so on, from grant funds would be decreased until they were totally on their own. Some of these men had veterans pensions and some did not. By pooling the money from the pensions, plus their income from the business, they were able finally to become completely self-sufficient.

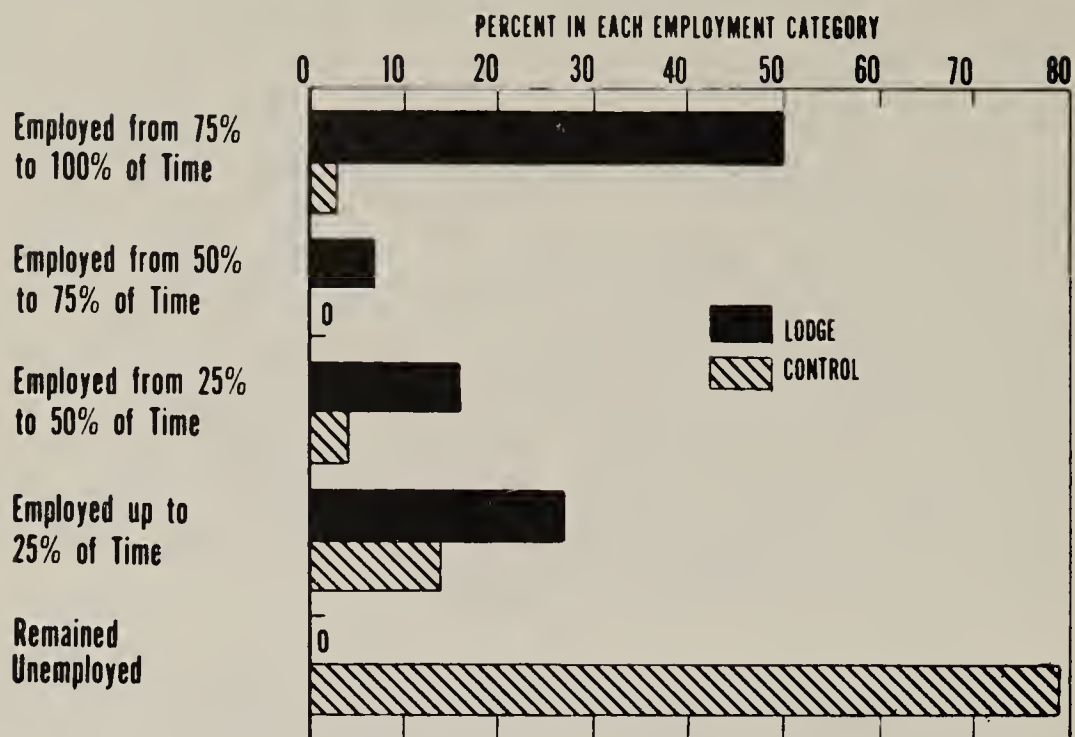
On the day when the lodge was closed, they moved into a middle class neighborhood where they had leased two houses and, of course, the inevitable happened. In the first few days in their new residences, one of the members told the neighbors that they were a group of "nuts from the mental hospital". The children who had been playing in the yard and romping through the house suddenly disappeared and a degree of isolation was established between the neighbors and the group members. Eventually, this isolation disappeared. One of the neighbors had a brother who was then in a mental hospital and she began conversing with the lodge members. Before long, other neighbors again became conversant. Eventually, it was necessary for the members to keep the children out of the house because they were taking too much of the members' time. Today the lodge still exists. These men have been completely on their own for almost two years.

The establishment of this lodge was a very carefully controlled experiment. The lodge members can be contrasted with other patients matched on age, diagnosis, and length of hospitalization. This comparison group participated in the same small-group treatment program on the same ward in the same hospital but instead of moving to the community lodge once they were eligible to leave the hospital they went to the kind of community program that was available to the typical patient who left the hospital either for a visit or by discharge. They participated in such programs as outpatient clinics and home care situations. At the termination of the study, the sample totaled 333 - 183 were in the nonvolunteer-nonlodge group; the remainder consisted of 150 matched patients, with 75 in the volunteer-lodge group and 75 in the volunteer-nonlodge group.

I wish now to show you some graphs comparing what happened to the individuals who went to the lodge with those who went into the typical community programs. I would like to show you some rather dramatic information about recidivism, employment, and the comparative costs of these two programs.

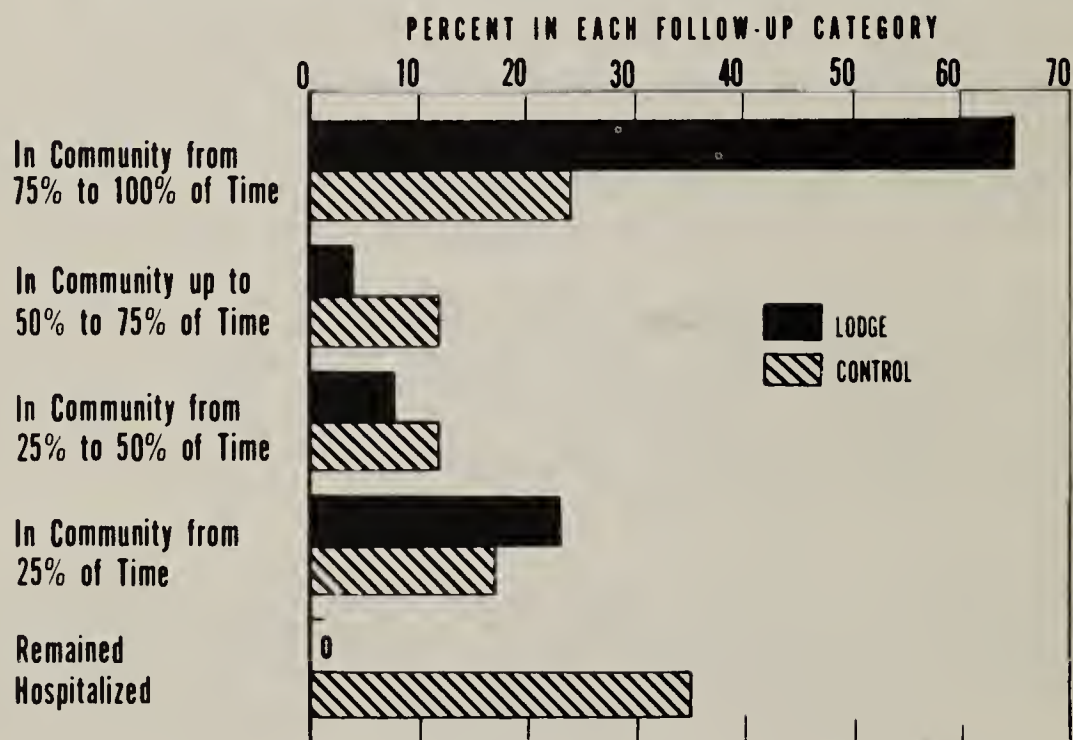
Compared to their matched control group of patients, a significantly greater proportion of the individuals in the working-living lodge situation were able to remain out of the hospital and assume employment. Sixty-five percent of the lodge group remained out of the hospital for six months, while 35% of the control group never left the hospital during the first six months and only 24% remained in the community for the full six month period.

COMPARISON OF THE PERCENTAGE OF TIME EMPLOYED FOR THE LODGE
AND CONTROL GROUPS FOR SIX MONTHS OF FOLLOW-UP.



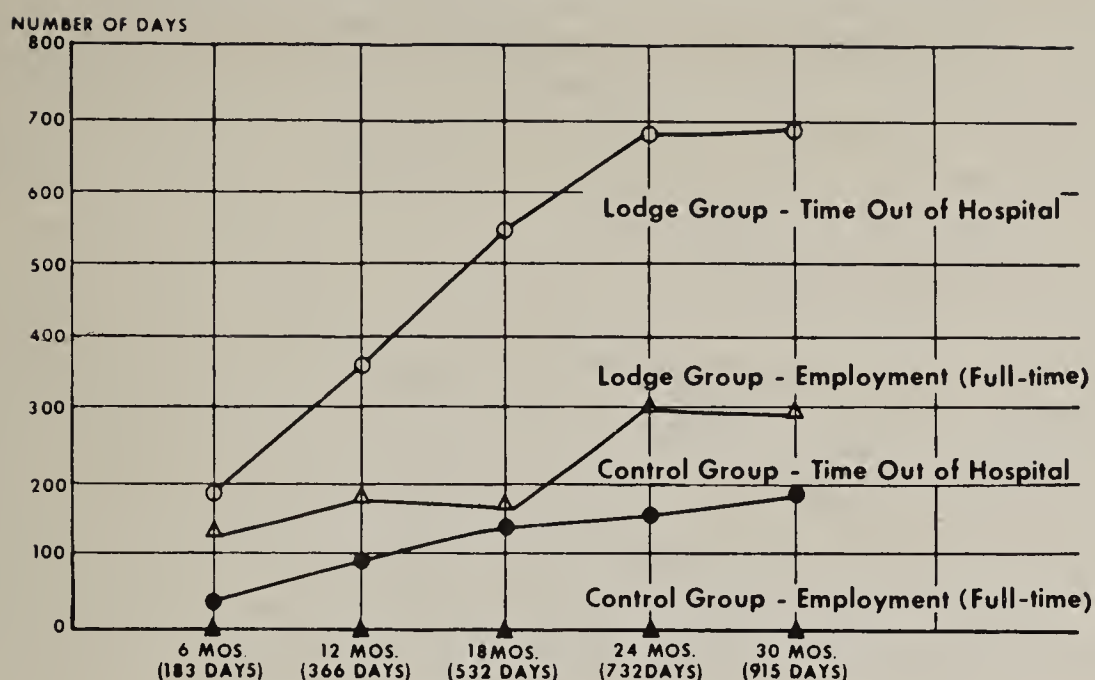
Fifty percent of the lodge group was employed full time for the entire six month follow-up period, while 79% of the matched controls were unemployed and only 3% worked for the full six months.

COMPARISON OF THE PERCENTAGE OF TIME IN THE COMMUNITY
FOR THE LODGE AND CONTROL GROUPS FOR SIX MONTHS OF FOLLOW-UP



Furthermore, the results obtained for the next two years are shown in this graph.

COMPARISON OF LODGE AND CONTROL GROUPS: TIME OUT OF HOSPITAL AND FULL-TIME EMPLOYMENT



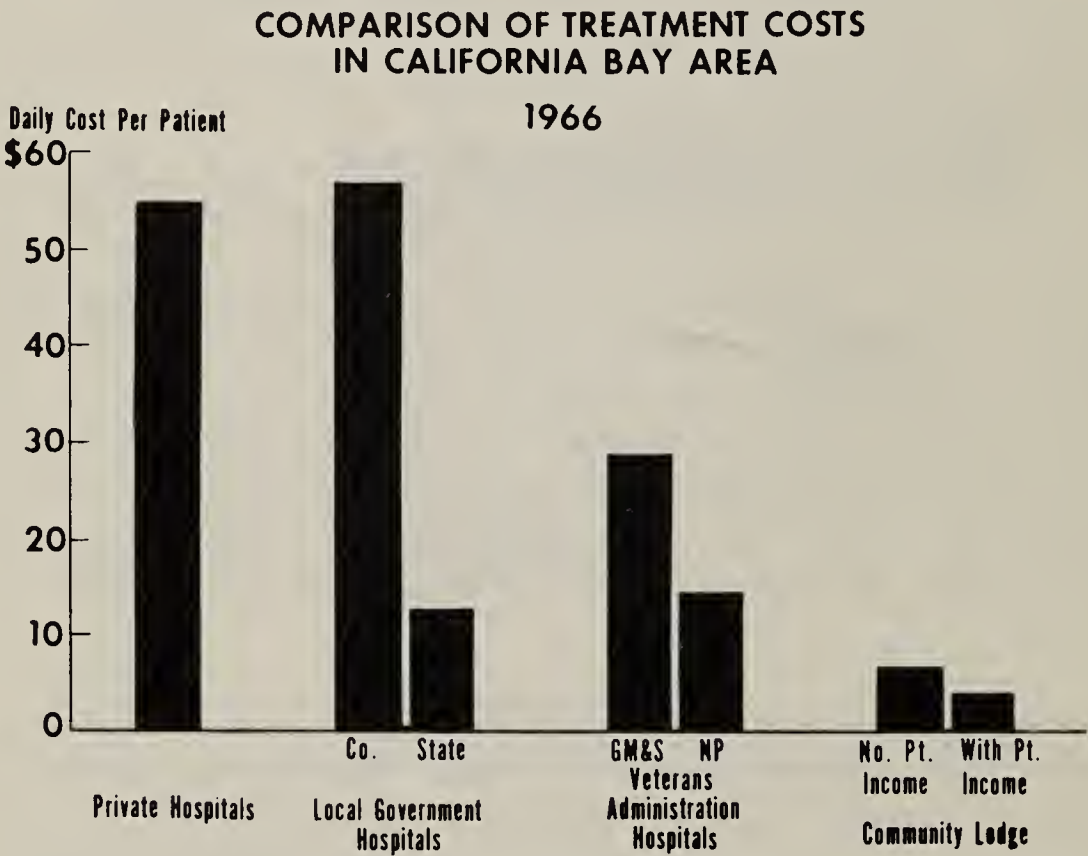
About 1/3 of those who arrived failed. But if a person survived these first few days he usually remained. This may be due to the VA population - none failed in Benton. The average length of time spent at the lodge by failures was less than a month. Seventeen percent of the lodge group left the lodge before the completion of their first six months in the community ostensibly in order to seek other employment. However, most of them remained unemployed after leaving the lodge.

So the community lodge was necessary for the maintenance of continuous employment and other aspects of adjustment. Thus, 2/3 of the members who left the lodge and were followed for as long as two years after leaving the lodge were unemployed during this time. The 1/3 who did obtain employment immediately upon leaving the lodge were employed only an average of 47 days during 18 months of follow-up. On the other hand, the median employment time for the control group was zero days during the entire follow-up period. Thus, the contribution of the lodge to continuous employment is very obvious.

As for other research findings, the lodge maintained but did not grossly affect individual behavioral adjustment. The lodge group revealed

themselves to be no less a disabled group when measured in terms of commonly used adjustmental criteria. Their seclusiveness, inarticulateness, eccentric behavior, apathy about goal accomplishment, and passivity in social interaction were no deterrent to their capacity to remain productively occupied in the community in what was, for them, an appropriately designed social situation. At the same time they could adopt participative social roles within their limited capacities.

The lodge was a much less expensive way of maintaining mental patients in society. This point is clearly illustrated in the graph shown here which compares treatment costs in the San Francisco Bay area. The cost of maintaining individuals in the community lodge (\$6.37) was less than half that for hospital care (\$14.34 at the Menlo Park Division of the Palo Alto VA Hospital). When the members contributed their earnings toward their own maintenance at the lodge, the cost was further reduced to \$3.90 per day per man. In contrast, the costs for treatment at other hospitals in the area were: \$55 at the local private hospital; \$56.75 at the local county hospital; \$12.26 at the local state hospital; and \$28.29 at the VA GM&S Hospital.



As far as work is concerned, this group of men had considerably more than 2000 janitorial jobs, some only requiring a day's work, in 2-3/4 years and they worked almost continuously after the first month that the lodge was in existence. They averaged more than three janitorial or gardening jobs per work day. As a group, they earned more than \$52,000 during this period.

In the community lodge a new and meaningful social role was created for these exmental patients and it led to success in both their contribution to the society and their feelings of achievement. It is quite true that the men at the lodge remained out longer because they were placed in the lodge to begin with, and they had jobs because employment was created for them. And, this is precisely the point of the entire community research project: Chronic mental patients are in need of a reference group that they can remain in and which will sustain them. This leads to a more constructive life.

At the lodge, there was continuous social stimulation, employment, companionship, a reason for remaining out of the hospital, the opportunity to do something constructive and to be perceived as a worthwhile human being. These men built for themselves a small society within whose norms they could live. They depended upon one another for survival. They could not do without this social organization. True, this may conceivably have been as far as they could go, and as far as society's usual norms are concerned this may not have been a normal existence. But this was a normal existence for them and it was an existence that was entirely acceptable to the rest of the community around them. As far as the larger community was concerned, these were exmental patients who were continuously moving away from the mental illness stigma because the community viewed the lodge as a residence and a business where fairly responsible men lived and worked at something constructive.

The location of the lodge was highly advantageous with respect both to its functions as a living unit and as a working unit. The lodge was socially compatible with the immediate neighborhood which was of a low social-economic status and persons who lived there had a high tolerance for minority group members. In such an environment a working-living social system of exmental patients had a good chance of being accepted by the neighborhood.

At the same time, the lodge was divided by little more than a free-way from a group of prosperous neighborhoods which provided a strongly expanding market for the janitorial services it offered as a working unit. In the period from 1964 to 1965 when the lodge janitorial business was growing into an established enterprise, the janitorial service industry within this area increased by 11.3%, employed 15.3% more persons, and paid 16.8% more in taxable payrolls.

This represented a substantially greater expansion of janitorial services in the lodge trading area than occurred in the surrounding metropolitan area.

Residents and businesses within the vicinity of the lodge were interviewed in reference to their attitudes about having the janitorial service in their neighborhood. In the middle of the interview, they were asked if they knew that the men who worked for the janitorial service also lived there and that they were a group of ex-mental patients. Prior to receiving this information, 81% of this group of interviewees were quite positive toward the lodge in terms of having the business in the neighborhood and using and referring their services. While some people were aware of the primary function of the lodge, it is interesting to note that after the additional information was supplied, 59% of the group remained the same in their attitude toward the lodge, 30% became more positive and only 11% were less positive.

In the course of the interviewing many spontaneous comments were made such as "they are a good bunch of guys" and "I'm not uneasy about a neighborhood with exmental patients because of the experience of living next door to the 49ers".

This group of expatients ranged from the classically characterized alcoholic, psychopath, anxiety and other neurotic reactions, to the schizophrenic of both short and exceedingly long previous hospitalization. It is most important to note that 55% of these men were in the chronically hospitalized category (greater than 2 years previous hospitalization). The mean number of weeks of previous hospitalization for the lodge sample was 292 or 5.6 years. Since the basic mental hospital problem in our society is what to do with the chronic schizophrenic of more than 3 years prior hospitalization, this study is particularly significant. It describes a social system where these persons can live in the community and do something constructive. It has been demonstrated that these "long termers" can sustain themselves and that they can work an eight hour day within the framework of a small society. However, just as significant is the adjustment of those who have frequent but short hospitalizations. They, too, present a problem for they might one day become chronically hospitalized. These "repeaters" usually were the leaders of the lodge. They preferred doing things for others more helpless than themselves, and the more disturbed lodge members afforded them this opportunity.

What was the reaction of the hospital to the lodge? To ascertain attitudes toward the lodge program by the professional and nonprofessional staffs of the hospital as well as the patients, questionnaires and structured taped interviews were obtained.

There was no significant difference on the questionnaire among the various professional groups although the psychology and social work groups ranked consistently higher on their attitude toward the lodge than the other professional groups. The most positive attitude of any group on the questionnaires was expressed by the personnel on the small-group experimental ward from which the lodge members came.

The interviews showed both positive and negative reactions in all groups. The negative responses from hospital personnel were stated to be due to a lack of sufficient information about the program so that they could not make any meaningful comment, or, in a few cases, a simple refusal to be interviewed. The positive comments were about the lodge being a very exciting and hopeful program. Many saw it as a very necessary resource for the hospital. Some thought it had influenced their own research and that it had been inspiring and stimulating. One of the psychiatrists said that the favorable comments tended to come from the more progressive physicians and the physicians who are more dynamically oriented; whereas the unfavorable comments came from those who are organically or custodially oriented.

I have presented data concerning the community lodge program. The data have shown that the program was an unqualified success when you consider our initial goal. We have described several aspects of the program, such as the establishment of a work situation and the characteristics of the lodge as a living situation. Now, I shall present a brief description of the lodge janitorial and yard service as a business, and demonstrate to you that exmental patients, living in a group supportive situation, can function at a high level of sophistication and can present to the general public a socially acceptable level of behavior. In doing this I will briefly present you a few of the typical and sometimes complex steps involved in the business of the 49ers Janitorial and Yard Service.

As with any business that offers its services to the public, the 49ers advertised in the usual manner. They had a listing in the yellow pages of the telephone directory, purchased advertising space in the local newspaper, and they printed business cards for distribution in the community. The card is quite complete in presenting basic information such as the kind of services offered, where they could be contacted, and the fact that they were bonded and insured. The card not only presents basic information but also performs the very important function of presenting the services of the business to the public in a socially acceptable form. Thus, their business practices placed these exmental patients on a par with other businesses which provide services to the public.

A potential client, in response to the business card or any other form of advertisement, would contact the 49ers, usually by telephone,

and request an estimate for a job. The estimate took place at the client's home or business at a prearranged time and if the estimate was accepted the client's name and the date when the job was to be performed were entered in the 49ers' Job Book. The format of this book also allowed for entries to be recorded for such items as the job number, the cost of the job, and the dates on which the client was billed and paid for the work. On line 9 is the summary statement indicating that the accounts receivable for March, 1966 was \$1,917.50. This figure represents the dollar value of work completed that month.

They also used a Cash Receipt Book. This bookkeeping instrument allowed for the recording of entries pertaining to the flow of funds into the business. In this regard, entries were made relating to the date money was received in payment of a job, the actual dollar amount of the job, and the client's name. This book was also used for the recording of income from other sources such as the coke, juke box, cigarette and candy machines which the lodge members had installed in the common dining hall. These machines were utilized by both the members and the general public. On line 29 is another summary statement. In this case, the sum of \$1,867.34 refers to the total amount of money received, regardless of source, for April, 1966.

Now that you have seen how funds flowed into the 49ers Janitorial and Yard Service, let's see how they dispersed some of these funds. I'll describe a page from the payroll ledger of the 49ers. The disbursement of funds to payroll is, of course, a straightforward operation. However, the 49ers had shaped it to fit their particular needs. For example, during this particular payroll period they paid crew chiefs 4.62% of the weekly receipts, deputy crew chiefs 3.61%, and workers 2.61%. Consider the gentleman whose name appears on the first line, Mr. _____, who is being paid by check No. 2309. His wage for the week was \$24.61. The sum includes \$3.68 for extra work on nights or Saturday and \$2.49 as his share of the penalty assessed other workers who, for some reason such as not working, had money deducted from their weekly salary. It was the norm at the lodge to redistribute the amount of money deducted from the salary of the penalized workers among those workers whose work performance was satisfactory or better. Thus, they established an additional reward-punishment system. His withholding tax was \$1.60, leaving him with a net pay of \$23.01 for the week. Check No. 2309 was drawn on the 49ers' account to pay Mr. _____. It was signed by two people; usually a consultant or lay leader and the 49ers' business manager who was one of the expatriates.

Now for a page from the Cash Disbursement Book. In this particular book were recorded such regular expenditures as the amount of the weekly payroll; a sum paid to the Coca-Cola Bottling Company for soda pop purchased by the members for use in their coke machine

located on the premises; and another direct financial outlay representing payment for janitorial supplies received from Richco, Inc., a janitorial supply house.

I have presented considerable information to you about a successful community experiment because it is the contention of our research staff that fully 50% of the patients in most mental hospitals could be moved to the community near their hospital in reasonably productive roles if the appropriate situations were established. As I have pointed out earlier, these situations have been arranged in both urban and rural areas. For example, the State Hospital at Benton, Arkansas, a rural hospital, and the Fort Logan Mental Health Center, an urban hospital, have established community lodges and developed work situations for the lodge members. Fort Logan, having established its lodge in the Denver metropolitan area, developed a janitorial and gardening service. However, the Arkansas State Hospital, which established separate community lodges for males and females, employed their men as grounds-keeping crews at the local golf courses and obtained work for their women as nursing assistants in training at the local nursing home. After a one-year period of testing by the employer, the female ex-patients were hired as full-time employees. Our Arkansas experience leaves no doubt that those who work on hospital wards could adequately handle the community situation. As a bonus, our experience shows that meaningful community roles for both patients and staff enhances the quality of everyone's life.

The research regarding this unique community subsystem, about which I have reported today, will be discussed in detail in a book now being prepared which is entitled TREATING MENTAL ILLNESS IN THE COMMUNITY: AN EXPERIMENT IN SOCIAL INNOVATION.

References

1. Fairweather, G. W., Simon, R., Gebhard, M.E., Weingarten, E., Holland, J. L., Sanders, R., Stone, G. B., and Reahl, J. E. Relative effectiveness of psychotherapeutic programs; a multicriteria comparison of four programs for three different patient groups. Psychological Monographs, No. 492, 1960, 74, No. 5.
2. Fairweather, G. W. (Ed.) Social Psychology in Treating Mental Illness: An Experimental Approach. New York: John Wiley & Sons, 1964.
3. Sanders, D. H. Social psychology in the treatment of mental illness: a model approach for treatment of addiction - The effect of group membership on community adjustment. In Rehabilitating the Narcotic Addict, Report of Institute on New Developments in the Rehabilitation of the Narcotic Addict, Fort Worth, Texas, Feb. 16-18, 1966. Vocational Rehabilitation Administration, U. S. Dept. of Health, Education and Welfare.
4. Sanders, D. H. Social innovation in treating mental illness: a community experiment. In Monograph - An Institute on Interagency Programming for Psychiatric Rehabilitation: An appraisal based upon recent legislation and research. Colorado State University Research Foundation, 1967.
5. Fairweather, G. W. Methods for Experimental Social Innovation. New York: John Wiley & Sons, 1967.
6. Fairweather, G. W., Sanders, D. H., Maynard, H. M., and Cressler, D. L. Treating Mental Illness in the Community: An Experiment in Social Innovation. Book in preparation.

Report of Group Discussions

An attempt will be made in this section to present the essence of the small group discussions which followed the presentations by the four Consultants for this seminar. No attempt will be made to identify the source of the comments or the suggested solutions. Major attention will be focused on topics of common interest to the four small groups.

In general, all four groups seemed to be saying "we are keenly interested in the prospects of behavior modification techniques as they apply to rehabilitation services in rehabilitation facilities". Numerous "hedging", questions or comments were offered which indicate the need for further Workshops or Seminars which would enable the participants to delve more deeply into the actual implementation or practice of behavior modification approaches to client service. For example, one question raised in one group asks, "Does behavior modification a la operant conditioning constitute unethical manipulation of the client?" This question has been raised in numerous circles even in the area of applied psychology which could, perhaps, be the one group one would expect to adopt this particular technique sooner than others. This question and its attendant attitudes suggest that the field of rehabilitation would have no responsibilities other than client rights of freedom of choice. It would seem, however, that society has dictated the responsibilities for rehabilitation by way of legislation and social mandate. Perhaps, like the field of Applied Psychology, we must face up to the fact that our major purpose in providing rehabilitation services is, in fact, to predict and control behavior. While many people feel that this would be an unethical manipulation of the client and his attendant rights for freedom of choice, the editor feels that adoption of such an attitude and major goal is the only thing which separates rehabilitation from the area of acute treatment of symptoms, whether in physical illness, mental or emotional problems, or educational or social deprivation. Society has stated that all people needing rehabilitation services should be provided them and that the goal of rehabilitation services must be the restoration of the individual to his maximum productive potential. Therefore, it is our concern to insure that the services provided from rehabilitation

agencies enable our clientele to attain these goals in the most expedient method possible. If in fact, then, operant conditioning or any other type of behavior modification approach yield the most expedient services to our clientele we would be quite remiss and, indeed, unethical if we did not provide them in the most comprehensive way possible.

Another point which was raised by all four of the smaller discussion groups relates to the involvement of rehabilitation facility staff in behavior modification programs. The major question here is what is the best way to involve the staff so that one can be assured of the greatest possible cooperation and enthusiastic participation among these staff members. Suggested solutions to this question ran the gamut from administrative fiat to very permissive soul-searching sessions closely resembling group psychotherapy. The most practical, hence effective, means for introducing staff to this type of procedure, thereby insuring their cooperation and participation, would be a more middle-of-the-road approach. The Consultants felt that most staffs would be quite easily persuaded in favor of behavior modification approaches if the administration would bring in a consultant who could adequately describe and demonstrate the benefits of such a program. This consultant, of course, must be an individual who can relate to the staffs in a meaningful manner.

It seemed to be the feeling of all four groups that this person must be able to make the translation from the academic world of theory and research to the applied world of rehabilitation practice. One point which must be considered in this vein is that many of the individuals involved in various facility staffs would have little or no formal education or training in any type of therapeutic approach resembling behavior modification techniques. This means that, in some cases, a fairly extensive tooling-up process must be accomplished before behavior modification approaches could be attempted. The consultants did feel, however, that this tooling-up process would be a reasonably simple and short-term process since the types of behaviors and approaches to their modification are quite clear cut and the theory involved is relatively simple to present and demonstrate. It seems, therefore, that this process of tooling-up is a matter to be contended with but one which presents no real obstacles or insurmountable problems.

Serious consideration was given in most of the groups concerning administrative matters involved in the implementation or initiation of behavior modification techniques in rehabilitation facilities. One factor which cannot be overstressed in this regard is that each situation must be considered as an individual situation with its attendant unique problems. In all probability, consultants will be needed in every case not only to present the theoretical and practical considerations of such an approach but also to assist in solving some of these administrative problems. Perhaps a brief summary statement concerning some of the problems that could be encountered may help to crystallize this discussion.

Rehabilitation facilities and programs must be organized in compliance with a large number of external regulations. These regulations are concerned with legal responsibility, confidentiality, disciplinary restrictions, physical safety and well being, et cetera. In effect, the organization and operation of the Center is answerable to a number of outside community regulators. The problems or questions raised by this particular area of interest then are such things as how much alteration of the organizational structure of a rehabilitation program or center will be tolerated by the administration, the patient sponsoring and referral sources, the staff professionals, the patient and/or clients and the community statutes and regulations. It must be reiterated that only on an individual basis can such questions be answered or problems solved.

One group discussed at some length the fact that an operant conditioning approach apparently involves a treatment of symptoms without attending to larger, perhaps more overriding problems, of the individual. For example, a distractingly talkative client in a Workshop program could be fairly easily conditioned not to disturb others with his verbal chatter. However, would reduction in his verbal chatter indicate that his chronic free-floating anxiety would have been alleviated by its reduction? It would seem that the consensus of most theoreticians involved in this area of work would be that the chronic anxiety would not be appreciably reduced but that some of the problem behavior components of the larger problem have been reduced which may enable the person to maintain a near normal existence.

In point of fact, one consultant stated that in this context the inappropriate response is the disorder, and not merely indicative of the substratum of pathology. This particular philosophical or theoretical approach to the business of rehabilitation seems to be gaining more and more recognition in the literature and particularly in innovative programs of recent vintage. The notion here seems to be simply that many people can be helped to maintain full time employment by the reduction of problem behavior and that they will therefore be able to maintain a near normal existence in spite of other problems, of greater magnitude perhaps, but of less threat to their continued employment. Using the aforementioned example again, the overly talkative individual may still be quite anxious but then there are many people in the world, working daily, who are also quite anxious and seem to make a reasonably satisfactory adjustment to their life situation. In other words, it would be impossible for rehabilitation or any other major movement in society to cope with all of the problems that any one individual client might bring to a treatment program.

This is not meant to imply that expediency should take the upper hand at the expense of quality programs but that we must look realistically at what we can achieve in a relatively short period of time to enable the individual to begin or resume operating reasonably normally in his environmental situation. This is based on the notion that the longer a person is out of the labor market or any other normal societal institution the more difficult it will be to assist him in making the transition from inactivity to activity. Perhaps it would be well here to interject an idea concerning rehabilitation's role and a responsibility which rehabilitation has perhaps abrogated in the past. Quite often the rehabilitation client's problems which are dealt with in rehabilitation facilities and centers, or rehabilitation field programs in general, are such that short-term measures can assist in ameliorating them. However, in many cases the individual's problems are completely changed and take on an entirely different meaning for him once he has returned to a normal living situation or a regular job or has returned to society as an active member. It is at this point that rehabilitation often has not followed through to assure that the individual has sufficient supportive help to maintain his new existence or his new approach to his environment. In many respects this individual is not

psychologically ready to cope with the decisions he must undertake until he has completed his rehabilitation program. Therefore, it would seem only logical that we extend our services to provide counseling at a time when the individual must make decisions not only about himself but about his participation in society as an active, productive and creative member. To draw this into sharper focus, many of the decisions we ask the rehabilitation client to make during his rehabilitation program concern problems which he does not understand or appreciate at the time we ask him to make the decision. Not until he is out in the world on his own, relying on his own initiative and strengths and/or weaknesses to carry him through, can he appreciate the full impact of his problems and the importance they have for his future. We should, therefore, in the editor's opinion, extend our counseling services to the individual after he has been placed in employment or after he is involved in the process of coping with his environment. Too often we seem to lose interest in the client once he has completed our services or programs.

Comments were made in most groups concerning the need in rehabilitation programs for controlled research which would compare the existing procedures and techniques with those instituted under a program of behavior modification. The results of studies cited by the four consultants are indeed exciting and would apparently have a great deal of application for the rehabilitation process in general. Before adopting this approach wholesale, however, it would seem only logical to attempt some clarification of the question concerning which services is most effective and produces the greatest result in the least amount of time, et cetera. If, in fact, behavior modification approaches do result in more efficiency and effectiveness in the rehabilitation process then a wholesale move toward that approach would seem in order.

This attention occasions interest in another point concerning the need for inclusion in our training programs of techniques and practices which would enable the professional to assume an active role in behavior modification programs. In addition, as one group brought out, it would seem to be most critical that the training institutions as well as the applied field

of rehabilitation make efforts to implement research findings already amassed so that there would be a quicker return to the clientele of the benefits of research efforts.

All four groups concluded their discussion sessions on the note that a recommendation should be made that pilot projects in behavior modification be established in rehabilitation facilities representative of the different program emphases, and that these be evaluated for their general application to all rehabilitation.

As a possible entree to this type of activity, it was recommended further that two- or three-day regional workshops, devoted exclusively to a single theory of behavior modification and the means for its implementation, be established across the country. It was recommended that the Association of Rehabilitation Centers, Inc., take an active role in generating such regional workshops to keep the interest in behavior modification approaches and techniques alive in the Rehabilitation Center movement and to encourage new Centers not included in this audience to participate in these deliberations. In summary, the groups felt that behavior modification techniques and approaches offer an excellent opportunity for the rehabilitation center movement to introduce a more expedient means of serving its clientele to meet the growing demand across the country. Therefore, we must make opportunities for our programs to incorporate such techniques to determine their benefit to our clientele.

It must be stated again that this discussion summary in no way captures all of the ideas or questions raised during these small group discussions. An attempt was made, however, to capture the essence of the group discussions to assist the reader in understanding the possible problems and necessary actions for implementation of behavior modification approaches in rehabilitation centers. The editors would be quite remiss if we did not compliment the participants in this seminar on their dedication to their task of coping with the questions raised by the consultants and the possible solutions offered by them for improving the services of the rehabilitation center movement. The participants approached the problem with enthusiasm and initiative and have demonstrated their administrative wisdom and vision by voicing the need for further Workshops or Seminars and research in this general area.

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